

INDIAN HEALTH SERVICE

**RESOURCE AND PATIENT MANAGEMENT SYSTEM
RPMS ADP SYSTEMS MANUAL**

Mental Health/Social Services

USER'S MANUAL

JULY 1997
VERSION 2.0

**OFFICE OF INFORMATION RESOURCE MANAGEMENT
DIVISION OF SYSTEMS DEVELOPMENT
ALBUQUERQUE, NEW MEXICO
PHONE (505) 248-4189**

Table of Contents

Overview - Mental Health and Social Services Reporting System.....	7
1.0 Introduction.....	9
1.1 The Data Entry Module.....	9
1.2 The Reports Module.....	10
1.3 The Manager Utilities Module.....	10
2.0 Data Entry Module.....	11
2.1 Update MH/SS Encounter Data - Screen Entry.....	12
2.1.1 Add Patient Visit.....	13
2.1.2 Add Non-Patient Record.....	22
2.1.3 Edit Record.....	23
2.1.4 Update Patient Information.....	24
2.1.4.1 Update Information (Designated Providers, Patient Flag).....	26
2.1.4.2 Patient Case Open/Admit/Closed Data.....	27
2.1.4.3 MHSS Patient Diagnosis List.....	29
2.1.4.4 Enter Local Service Site.....	39
2.1.4.5 Personal History Information.....	39
2.1.4.6 Print an Encounter Form.....	42
2.1.4.7 None of the Above (Quit).....	44
2.1.5 Display Record.....	44
2.1.6 Delete Record.....	47
2.1.7 Print Encounter Record.....	49
2.1.8 Health Summary.....	52
2.1.9 SOAP/CC Edit.....	54
2.1.10 Switch Dates.....	55
2.1.11 Search List.....	56
2.1.12 Quit.....	56
2.2 Update MH/SS Encounter Data - Roll'N Scroll Mode.....	57
2.3 Patient Centered Data Entry.....	60
2.3.1 Patient Contact Data.....	62
2.3.2 Treatment Plan Update.....	63
2.3.3 Problem List Update.....	64
2.3.4 Update Case Data.....	65
2.3.5 PCC Visit Details.....	65
2.3.6 Last MH/SS Visit.....	66
2.3.7 Display Meds.....	66
2.3.8 Appointments.....	67
2.3.9 Quit.....	70
2.4 Group Form Data Entry.....	71
2.5 Activity Record Log Data Entry.....	73
2.6 Update Patient Data.....	74
2.7 Display Patient's Last MH/SS Visit.....	75
2.8 Print Encounter Record.....	76
2.9 Update MH/SS Patient Treatment Plans.....	78
2.9.1 Update (add, edit, delete) a Treatment Plan.....	79
2.9.1.1 Add Treatment Plan.....	80
2.9.1.2 Edit a Plan.....	82

2.9.1.3	Delete Tx Plan	83
2.9.1.4	Enter TP Review	84
2.9.1.5	Update a TP Goal	85
2.9.1.6	Display/Print Plan	85
2.9.1.7	Health Summary	88
2.9.1.8	Search List	88
2.9.1.9	Quit	88
2.9.2	Display/Print a Treatment Plan	89
2.9.2.1	Display/Print Plan	89
2.9.2.2	Health Summary	90
2.9.2.3	Next Screen	90
2.9.2.4	Previous Screen	90
2.9.2.5	Down a Line	90
2.9.2.6	Up a Line	90
2.9.2.7	Print List	90
2.9.2.8	Search List	91
2.9.2.9	Quit	91
2.9.3	Print List of Treatment Plans Needing Resolved	91
2.10	Generate Health Summary	93
2.11	Display Record Options	95
3.0	Reports Menu	105
3.1	Patient Listings	109
3.1.1	Active Client List	110
3.1.2	Patient General Retrieval	112
3.1.2.1	Selecting Search Criteria	113
3.1.2.2	Selecting the Report Type	114
3.1.2.3	Selecting Print Items	115
3.1.2.4	Selecting a Sort Category	116
3.1.3	Designated Provider List	118
3.1.4	Patients with at Least N Visits	120
3.1.5	Active Client List Using Case Open Date	122
3.1.6	Patients Seen by Age and Sex	124
3.1.7	Patient List for Personal Hx Items	129
3.1.8	Cases Opened But Patient Not Seen in N Days	130
3.1.9	Tally Cases Opened/Admitted/Closed	132
3.2	MH/SS Record/Encounter Reports	134
3.2.1	List MH/SS Records, STANDARD Output	135
3.2.2	List MH/SS Records, GENERAL RETRIEVAL Output	138
3.2.3	Potentially Billable MH/SS Visits	142
3.3	Workload/Activity Reports	144
3.3.1	Activity Report (GARS #1)	145
3.3.2	Activity Report by Primary Problem (GARS #2)	147
3.3.3	Activity Record Counts	150
3.3.4	Program Activity Time Reports	153
3.3.5	Frequency of Activities	156
3.3.6	Frequency of Activities by Category	159
3.4	Problem Specific Reports	162
3.4.1	Suicide Report (Age and Sex)	163

3.4.2	Abuse Report (Age and Sex)	165
3.4.3	Frequency of Problems	168
3.4.4	Frequency of Problems (Problem Code Groupings)	171
3.4.5	Frequency of Problems by Problem Category	174
3.5	PCC Management Reports	177
3.6	Q-Man (PCC Query Utility)	178
3.7	Print Standard MH/SS Tables	179
4.0	Manager Utilities Module	180
4.1	Update Site Parameters	181
4.2	Export Utility Menu	185
4.2.1	Generate MHSS Transactions for HQ	186
4.2.2	Display a Log Entry	187
4.2.3	Print Export Log	187
4.2.4	Re-generate Transactions	188
4.2.5	Re-set Data Export Log	188
4.2.6	Check Records Before Export	189
4.2.7	Print Error List for Export	190
4.2.8	Create Output File	191
4.2.9	Mental Health and Social Services Extract Record Definition	192
4.3	Re-Set Patient Flag Field Data	196
4.4	Display Log of Who Edited Record	197
4.5	Add/Edit Local Service Sites	198
4.6	Add Personal History Factors to Table	198
	Appendix	200
	Word-Processing Screen Help	203
	Activity Codes and Definitions	220
	Purpose of Visit Codes	227
	Definitions for Purpose of Visit Codes	233
	MH/SS to PCC Link	256
	MH/SS PROBLEM CODE TO ICD9 CROSSWALK	260

Overview - Mental Health and Social Services Reporting System

The Mental Health/Social Service reporting system is a discipline specific clinical sub-component of the PCC. It is designed for use at a specific site and articulates with the registration module for patient information, the PCC for medical information, and the pharmacy module for medications issued by IHS pharmacies. While the module does not require that PCC be operational in a specific site, it is dependent on the registration module, and we strongly recommend that it be implemented as an complement to the PCC in order to take advantage of the other components of the RPMS that use the PCC.

The module combines the IHS reporting requirements from the Generic Activities Reporting System (GARS) and the Patient Care Component (PCC) of the RPMS. These data items constitute the central core of the reporting system. A wide range of options for capturing other data have been added, at the request of field programs, and it is this combination of data items which gives the module maximum flexibility.

The system captures and stores three basic kinds of information in a MH/SS data file: clinical information about specific patients (stored in the MH/SS file in DSM-IV diagnostic terms and passed to PCC in ICD-9-CM Diagnostic terms); behavioral aspects of clinical problems, couched in descriptive terms to allow for recording of a wide range of problems which are not well identified using diagnostic coding (problem codes which are an expansion of V-Codes and which are stored in the MHSS module using the descriptive terms and passed to the PCC in appropriate ICD-9-CM V-Codes); and information about both the clinical and non-clinical activities of providers. When appropriate, the PCC data files are automatically updated from the MH/SS data file, eliminating the need for reporting on more than one system.

Confidentiality of information has always been of concern to Mental Health and Social Service providers. Several aspects of this module attempt to address these concerns.

Programs can control the specificity of the information passed to the PCC. Sensitive issues can be "glossed", to preclude inadvertent disclosure, without significant loss of data for clinic, management and billing purposes. These options can also be used to tailor an individual providers reporting requirements when they differ from the rest of the program staff,

Information in the MH/SS data file can only be accessed by program staff, so programs have responsibility for their own data entry. To facilitate the data entry process, users can **EITHER** code their own data on the standard MH/SS encounter form (IHS-524), a group(ed) services work sheet or an activities log and rely on support staff for data entry, **OR** enter the data directly, using one of several data entry options.

When the direct data entry option is used, a "hard-copy" of the record can be generated for inclusion in patient's chart. To address confidentiality concerns about including detailed information in the patient's chart, providers who enter their own data can print a "hard copy" of the record with the information in Presenting Problem, the Subjective/Objective, the POV Label and the Comments fields suppressed, and with a note to see the provider for details of this contact.

An option for recording extensive Treatment Plan information is also available. Treatment Plan data are stored in the MH/SS patient file and a "hard-copy" of the plan, which includes a routine review component, can be generated to meet clinical and quality assurance requirements. Version 2 integrates the Treatment Plan more directly into the clinical record and the data entry process.

Locally, a MH/SS health summary for an identified patient which uses data from the MH/SS data file, the PCC data file, the Pharmacy data file and the Registration file can be generated by MH/SS program staff.

A very powerful set of standard and **ad-hoc** report writers, which use the MH/SS data file, data elements from the PCC and the Registration file is available for local use.

On a regularly scheduled basis, statistical extracts of site specific data will be forwarded to Headquarters and merged into a service-wide data file which will serve as the aggregate common data base for both and IHS and Tribal programs using the system. Both Area and Local programs will have access to these files using the standard IHS protocols.

In addition to providing much more precise information to the local clinical staff involved in managing these conditions, and linking these program services to the billing modules driven by PCC, the system captures the kinds of management level data which have become particularly important for local and service-wide accountability.

The possibility of using a single system to address all these reporting concerns is, of course, of considerable interest to the potential user. In addition, the specific attention to data issues concerned with third party billing, e.g., case definition, CPT procedure codes, and treatment plan components, strengthen the module.

1.0 Introduction

The Mental Health and Social Services System (MHSS) provides a standard tool for automating the entry of MH/SS data. There are three main modules specific to the MHSS that are accessible from the system's main menu (see below):

- MH/SS Data Entry
- Reports Menu
- Manager Utilities

```
*****  
** IHS Mental Health/Social Services System **  
*****  
Version 2.0  
  
SELLS HOSPITAL/CLINIC  
  
DE      MH/SS Data Entry Menu ...  
RPTS    Reports Menu ...  
MUTL    Manager Utilities ...
```

All the data entry, management, and retrieval for the MHSS are performed with these three menu options. This User's Manual presents descriptions of these options and their submenus and provides detailed instructions for using all aspects of the system. You should read the entire manual before using the MH/SS system.

In addition to the above modules, you will have access to options for printing and browsing health summaries. This option is provided on the data entry screen of the MH/SS to allow you to review and print a patient's health summary with a minimum of effort. Detailed information on health summaries is available in the Health Summary System User's Manual and will not be covered in this guide.

1.1 The Data Entry Module

Most MH/SS processing work is handled in the Data Entry module on the MH/SS Main Menu. All encounter information can be directly entered by a provider at a terminal or a provider may record data manually on forms for later entry by program support staff. Once the visit data has been entered, an MH/SS-generated form that contains all information about the patient encounter can be printed and placed in the patient's chart. Also available on the Data Entry Menu is a submenu of options to update and revise treatment plans.

1.2 The Reports Module

A set of predefined reports is available from the MH/SS system for administration purposes and analysis of activity and patient data. The report categories available from the Reports Menu option on the MH/SS main menu are:

- Patient Listings
- MH/SS Record/Encounter Reports
- Workload/Activity Reports
- Problem Specific Reports

In addition to the predefined reports, the MH/SS system provides a general retrieval report option. Use this option to create custom reports to meet the needs of your facility. This option is available from the Reports Menu.

When the interface with the PCC is enabled, all patient clinical data in the MH/SS database is shared with the PCC in an automated fashion. The PCC then becomes a much more complete repository of all patient care information, allowing managers to use the search tool, Q-Man, on this more complete information system for extensive and detailed report outputs.

1.3 The Manager Utilities Module

The Site Manager uses the MH/SS Manager Utilities module to set the special parameters for this software, which customizes its features to meet your site's specific needs. Use the menu options to:

- Export data to headquarters
- Re-set patient flag indicators
- Update site parameters
- Display a log of who edited a particular record

NOTE: You must set the MH/SS system site parameters before using the system for the first time. You may modify these parameters, as needed.

2.0 Data Entry Module

Use the Data Entry Module of the Mental Health/Social Services System to enter, edit, view, and print patient data. An option is also provided for tabulating the number of MH/SS data entry forms that were processed within a given time period.

- **To access the Data Entry Menu, type “DE” at the IHS Mental Health/Social Services System Main Menu and press <RETURN>.**

The Data Entry Menu will be displayed. Each option in the Data Entry Menu will be detailed in this chapter.

```
*****  
**      IHS Mental Health/Social Services System      **  
**                      Data Entry Menu                      **  
*****  
                          Version 2.0  
  
                        ALBUQUERQUE HOSPITAL  
  
SDE  Update MH/SS Encounter Data - Screen Entry  
RDE  Update MH/SS Encounter Data (roll n scroll mode)  
PDE  Patient Centered Data Entry  
GRP  Group Form Data Entry  
ACT  Activity Record Log Data Entry  
UPT  Update Patient Data  
PLV  Display Patient's Last MH/SS Visit  
PRT  Print Encounter Record  
TPU  Update MHSS Patient Treatment Plans ...  
GHS  Generate Health Summary  
DSP  Display Record Options ...  
  
Select MH/SS Data Entry Menu Option:
```

Data Entry Menu

The two menu options available for data entry of encounter data are Update MH/SS Encounter Data - Screen Entry (SDE) and Update MH/SS Encounter Data (Roll’N Scroll Mode) (RDE). Both options prompt for exactly the same information, although the format of the entry is different. Use the SDE option to enter data on a screen that resembles the encounter form that providers fill out manually. This option is best for users who typically do not perform a lot of data entry or who are not very familiar with the system. Use the RDE to display the “roll and scroll” interface that data entry operators typically use. The option you select will depend upon your preference. Both of these options are detailed below.

2.1 Update MH/SS Encounter Data - Screen Entry

Data may be entered into this system directly by providers or recorded manually on forms for later processing by data entry staff. Use either method to record data for individual encounters, group services, or provider activities. When you enter encounter data, a hard copy of the record can be printed to include in the patient's chart.

- **To enter encounter data, type “SDE” at the prompt in the Data Entry Menu and press <RETURN>.**

The Update MH/SS Records Screen will be displayed.

MH/SS Data Entry Module

* Update MH/SS Records *

Please enter the appropriate set of defaults to be used in Data entry.
This applies to default clinic, location, community and program.

Select one of the following:

M MENTAL HEALTH DEFAULTS
S SOCIAL SERVICES DEFAULTS

Which set of defaults do you want to use in Data Entry: M

Enter ENCOUNTER DATE: TODAY

Update MH/SS Records Screen

- Type the letter of the default you want to edit next to the “Which set of defaults do you want to use in Data Entry:” prompt and press <RETURN>.

- Type the date for which you want to view records next to the “Enter Encounter Date:” prompt and press <RETURN>.

A selection list of records that have been entered for the encounter date will be displayed. If no records exist for that particular date, an indicating message will be displayed, as shown below. The available data entry actions are listed at the bottom of the screen. Each action is detailed in the following section(s).

Update MH/SS Forms	Feb 12, 1997 10:30:27	Page: 1 of

Date of Encounter: FEB 12, 1997		

No records currently on file for FEB 12, 1997		
?? for more actions + next screen - prev screen		
AV Add Patient Visit	DS Display Record	SO SOAP/CC Edit
AN Add Non Pat Record	DE Delete Record	SL Search List
ED Edit Record	PE Print Enc Record	Q Quit
AP Update Pat Info	HS Health Summary	
Select Action: AV//		

- To enter data, type the corresponding letters at the “Select Action:” prompt in the Update MH/SS Forms Screen and press <RETURN>.

2.1.1 Add Patient Visit

- To add data for a patient encounter, type “AV” at the “Select Action:” prompt and press <RETURN>.
- Type the name, health record number, social security number, or date of birth of the patient whose encounter data you want to enter next to the “Type the Patient’s HRN, Name, SSN, or DOB:” prompt and press <RETURN>.

Sex, date of birth, social security number, and all known health record numbers from the registration file will be displayed.

NOTE: If more than one patient matches the identifying information, a list of these patients will be displayed.

```

TYPE THE PATIENT'S HRN, NAME, SSN OR DOB

Patient: Wilson, Jimmy
          M 01-02-50 333882211 AH 59294
          Ok? Yes// <RETURN>

Enter PRIMARY PROVIDER: ADAM, ADAM// <RETURN>
    
```

- Press <RETURN> at the "Ok? YES//?" prompt to verify the patient's identity (since the data you type will be entered into this patient's chart).
- Type the name of the patient's primary provider next to the "Enter Primary Provider:" prompt and press <RETURN>.

The Mental Health/Social Services Contact Update Screen will be displayed. Not all the data items on the screen require entries. The required data items are underlined. Many of the data items are already completed. You may change these default values as needed.

```

* MENTAL HEALTH/SOCIAL SERVICES CONTACT UPDATE *
Encounter Date: APR 24,1997      User: JONES, SUE
Patient Name: WILSON,JIMMY      DOB: 1/2/50  HR#: 59294
-----
*** Contact Demographics ***
PROGRAM: MENTAL HEALTH          LOCATION OF ENCOUNTER: ALBUQUERQUE HOSPITAL
CLINIC: MENTAL HEALTH           APPOINTMENT OR WALK-IN: APPOINTMENT
TYPE OF CONTACT: OUTPATIENT CLIN COMMUNITY OF SERVICE: ALBUQUERQUE
ANY SECONDARY PROVIDERS?: N
*** Clinical Data Items ***
CLINICAL DATA ITEM:            PURPOSE OF VISIT (POVS):
COMMENT:
ANY PATIENT EDUCATION DONE? N  PLACEMENT DISPOSITION:
*** Administrative Data Items for this Contact ***
ACTIVITY CODE:                  ACTIVITY TIME:          # SERVED: 1  FLAG FIELD:
EVALUATION & MANAGEMENT CPT:  INTERPRETER UTILIZED?
-----
COMMAND:                        Press <PF1>H for help  Insert
    
```

NOTE: If you have not entered data in all the required fields and try to exit, the screen below will be displayed. Encounter data will not be entered into the system without all of the required data items.

THE DATA COULD NOT BE FILED. Page 1, ACTIVITY CODE is a required field Page 1, ACTIVITY TIME is a required field
--

Some of the data fields have screens that request additional information. Each of these screens and the data items they contain are displayed in this section. Instructions, help tips, and patient information are displayed below the line at the bottom of the main data entry screen. The information displayed varies according to the field (e.g., if you type a “??” and press <RETURN> at the Program field, three response choices will be displayed).

Each piece of information collected during the Add Patient Visit is defined here and described in detail in the order in which it is displayed on the Mental Health/Social Services Contact Update Screen.

- **ENCOUNTER DATE.** The date the MH/SS encounter occurred. Enter this date at the beginning of the data entry process, and it is incorporated automatically on the main data entry screen. You do not need to reenter the date.
- **USER.** The name of the person logged into the computer to enter data. The name is entered automatically by the system.
- **PATIENT NAME, DOB, HRN#.** These patient identifiers are inserted in the data entry screen from the patient registration file based upon the patient selected.
- **PROGRAM.** Indicate the program affiliation of the primary provider. In most cases, this field will already have a default value.
- **LOCATION OF ENCOUNTER.** The location where the activity occurred. Use the two-digit location code or name from the standard IHS table.
- **CLINIC.** If the encounter took place within the context of a scheduled clinic other than MH or SS, enter the type of clinic (e.g., Chronic Disease or Pediatric).
- **APPOINTMENT/WALK-IN.** Indicate if the patient had an appointment.
- **TYPE OF CONTACT.** This determines if a PCC visit is generated from the MH/SS record. Select the most appropriate designation from the Type of Contact list.

- If you enter Outpatient or Home, you must enter the arrival time, as displayed below. Enter the time and press <RETURN> to continue.

ARRIVAL TIME: **2:15**

- **COMMUNITY OF SERVICE.** The community where the encounter took place. Use the standard IHS state/county/community codes. All IHS facilities are located within an identifiable community.
- **ANY SECONDARY PROVIDERS.** Enter any secondary providers (e.g., any providers that are not primary).
- **CLINICAL DATA ITEM.** When you press <RETURN> at the "Clinical Data Item:" prompt, the Enter/Edit Clinical Information Screen will be displayed. The data items on this screen are detailed below.

```
***** MH/SS CONTACT UPDATE *****      Page 2
*** Enter/Edit CLINICAL Information ***
Encounter Date: APR 24,1997@12:00   User: JONES,SUE
Patient Name: WILSON,JIMMY         DOB: 8/15/95  HR#: 112696
-----
CHIEF COMPLAINT:

SUBJECTIVE/OBJECTIVE/ASSESSMENT/PLAN:

Display Currently Dispensed Medications? N MEDICATIONS PRESCRIBED:

ANY PROCEDURES?: Y

ANY TREATED MEDICAL PROBS?: N
```

Enter/Edit Clinical Information Screen

CHIEF COMPLAINT. Type the information that describes the major reason the patient sought services next to the "Chief Complaint:" prompt and press <RETURN>. Data entered in this field will be displayed on the MH/SS Visit Record when it is printed.

SUBJECTIVE/OBJECTIVE/ASSESSMENT/PLAN. Press <RETURN> at the Subjective/Objective:" prompt to enter/edit/view narrative history, physical examination and progress notes, and subjective/objective observations. Data

entered in this field will be displayed on the MH/SS Visit Record when it is printed.

```
1>Patient needs four counseling sessions.  
2> <RETURN>  
EDIT Option:
```

- To display a list of available edit options, type “??” at the “Edit Option:” prompt and press <RETURN>.

MEDICATIONS PRESCRIBED. When you type “Y” (Yes) at the “Display Currently Dispensed Medications?” prompt and press <RETURN>, the Output Browser Screen for Currently Dispensed Medications will be displayed.

```
OUTPUT BROWSER          May 21, 1997 14:59:52      Page:  1 of  1  
Medication List for WILSON,JIMMY  
  
*** Medications Prescribed entries in MHSS Database for last 2 years ***  
  
The last of each type of medication from the PCC Database is displayed below.  
  
Enter ?? for more actions                >>>  
+ NEXT SCREEN      - PREVIOUS SCREEN    Q  QUIT  
Select Action: +//
```

Output Browser Screen for Currently Dispensed Medications

- Type “Q” (Quit) at the “Select Action:” prompt and press <RETURN> to redisplay the Enter/Edit Clinical Information Screen.
- Press <RETURN> at the “Medications Prescribed:” prompt.

A list of medications prescribed will be displayed. Prescriptions will be coded and added to the PCC from the Pharmacy system, not the MH/SS data file. You **must** record the medications here in case the patient does not have the prescription filled by the IHS pharmacy.

```
1>Medications listed  
2>here  
EDIT Option:
```

- To display a list of available edit options, type “??” at the “Edit Option:” prompt and press <RETURN>.

ANY PROCEDURES. If procedures were performed during the visit, type “Y” (Yes) at this prompt and press <RETURN>.

The Enter CPT Procedures Screen will be displayed, as shown below.

```
***** ENTER CPT PROCEDURES *****  
  
CPT procedure codes currently recorded for this visit:  
10001 DRAINAGE OF 2ND SKIN LESION  
  
Select CPT:
```

Enter CPT Procedures Screen

- Type the CPT code or a description of the procedure next to the “Select CPT:” prompt and press <RETURN> to record your entry.

ANY TREATED MEDICAL PROBLEMS. Type “Y” (Yes) at the “Any Medical Problems:” prompt to view/enter a medical problem treated during the encounter.

The screen below will be displayed.

```
* MENTAL HEALTH/SOCIAL SERVICES RECORD EDIT *  
Encounter Date: APR 24,1997@12:00   User: JONES,SUE  
Patient Name: WILSON,JIMMY         DOB: 1/2/50 HRN: 59294  
-----  
MEDICAL PROBLEM:  
MEDICAL PROBLEM:  
MEDICAL PROBLEM:  
MEDICAL PROBLEM:  
MEDICAL PROBLEM:
```

Medical Problem Edit Screen

- Type the patient’s medical problem next to the “Medical Problem:” prompt and press <RETURN> to record your entry.
- To view a list of available medical problems, type “??” at the “Medical Problem:” prompt and press <RETURN>.

- **PURPOSE OF VISIT.** When you press <RETURN> at the Purpose of Visit prompt in the Mental Health/Social Services Contact Update Screen, the “MH/SS Record Entry – Purpose of Visit Update” Screen will be displayed. Providers code and describe the nature of the problem with a brief narrative. Every encounter record must have at least one purpose of visit identified. This is the **most important** section of the encounter record. The options on this screen are detailed below.

```
***** MH/SS RECORD ENTRY - PURPOSE OF VISIT UPDATE *****  
  
Encounter Date: APR 24,1997@12:00   User: JONES,SUE  
Patient Name: WILSON,JIMMY         DOB: 8/15/95   HR#: 112696  
-----  
DIAGNOSIS:      NARRATIVE:  
DIAGNOSIS:      NARRATIVE:  
DIAGNOSIS:      NARRATIVE:  
DIAGNOSIS:      NARRATIVE:  
DIAGNOSIS:      NARRATIVE:  
  
AXIS IV:  
AXIS IV:  
AXIS IV:  
AXIS V:  
  
-----  
Patient's Diagnoses from last 2 visits:  
4/24/97 45.2 ABUSIVE BEHAVIOR (ALLEGED), EMOTIONAL  
Provider: AA  AXIS IV:   AXIS V: 6
```

Purpose of Visit Update Screen

NOTE: The patient’s POV for the previous visit will be displayed at the bottom of the screen, as shown here. The Axis IV and Axis V fields (detailed below) are also contained on this screen for data entry, but are not required fields.

DIAGNOSIS (POV CODE). Type either the one- or two-digit MH/SS Purpose of Visit Codes or the more specific five-digit DSM-III-R diagnostic codes at the “Diagnosis:” prompt and press <RETURN>. Do not use the V-Codes as a purpose of visit code. The code used will govern the information passed to PCC, so attention to these issues is required, for an overview of the MH/SS to PCC link. Type “??” at the “Diagnosis:” prompt to view options available.

NARRATIVE (POV NARRATIVE). Type a brief description of the diagnosis addressed for each POV Code at the “Narrative:” prompt and press <RETURN>. The narrative may be simple (e.g., the label “Marital Problem”) or a more detailed statement. When a DSM-III-R Diagnosis Code is used as a POV, the narrative will be passed to the PCC. When a MH/SS Problem Code is used as a POV, the setup option in the Site Parameters file will dictate the information passed to the PCC.

AXIS IV (MAJOR PSYCHOSOCIAL OR ENVIRONMENTAL PROBLEM). Type one of the codes listed at the "Axis IV:" prompt to identify the major problem, when relevant. Type "??" at the "Axis IV:" prompt to view the options available.

AXIS V (Functional Level from DSM). For each contact, code the patient's functional level using the GAF scale (0-100).

PROBLEM LIST UPDATE. When you finish entering a POV code and narrative, the screen below will be displayed.

Add this PROBLEM to the MH/SS Problem List? N	Add this Problem to the PCC Problem List? N
--	--

- Type "Y" (Yes) or "N" (No) at the "Update the Patient's Problem List?:" prompt and press <RETURN>.
- Type "Y" (Yes) or "N" (No) at the "Add this Problem to the PCC Problem List?" and press <RETURN>.
- **COMMENT.** Type the provider's comments on the patient, patient's care, activity, etc., at the "Comment:" prompt. Any comments the provider adds to this field stay in the MH/SS data file and are printed on the MH/SS health summary only. You may enter 2 to 200 characters in the field.
- **ANY PATIENT EDUCATION DONE?** Use this field to enter if the patient was briefed.
- **PLACEMENT DISPOSITION.** Enter a placement disposition (e.g., inpatient psych, IHS Hospital, resident, etc.) in this field, as appropriate. Type "??" at the "Placement Disposition:" prompt to get a list of available options. The following screen will be displayed.

Enter the Facility to which the patient was referred FACILITY REFERRED TO:

- Type the name of the placement facility at the “Facility Referred To:” prompt and press <RETURN> to record your entry.
- **ACTIVITY CODE.** Record the type of activity that occurred at the “Activity Code:” prompt and press <RETURN>. Type “??” at the “Activity Code:” prompt to get a list of available options.
- **ACTIVITY TIME.** Type the activity time in minutes at the “Activity Time:” prompt and press <RETURN>. Enter up to three digits.
- **NUMBER SERVED.** Type the number of persons directly served during the reported activity at the “# Served:” prompt and press <RETURN>. Enter up to three digits. Use one for direct patient care.
- **FLAG FIELD.** This is an undefined code field for local use. The value in this field may be 0 through 9. These numbers are defined locally to incorporate data or a comment that is not otherwise captured during the data entry process.
- **EVALUATION AND MANAGEMENT CPT.** Type the evaluation and management CPT code applicable for this visit next to the “Evaluation and Management CPT:” prompt and press <RETURN>. The CPT code must be an active H-code in the 99200-99500 range.
- **INTERPRETER UTILIZED.** Use this field to record the presence of an interpreter during the patient encounter. Do **not** use this field as a substitute for recording effort where the secondary provider is considered a co-therapist. Use the Provider’s field to enter multiple providers for a single encounter.
- After you enter all data for the encounter record, press <RETURN> to display the Mental Health/Social Services Contact Update Screen.
- Type “E” at the “Command:” line at the bottom of the screen and press <RETURN> to exit the screen.
- Type “Y” (Yes) at the “Save changes before leaving form (Y/N)?” prompt and press <RETURN> to save your changes.
- When the record is complete, press <RETURN>.

The Other Information Menu will be displayed. Use this menu to update other information in the patient’s file. For instructions on using the options in this menu, see Section 2.1.4 Update Patient Information.

- Type "7" at the prompt and press <RETURN> to Quit.

The record selection list will be displayed again.

2.1.2 Add Non-Patient Record

Providers use the Add Non-Patient Record option to record activities that did not involve one-on-one patient contact (e.g., administrative activities, community services, and referral tasks).

- To add a non-patient record, type "AN" at the "Select Action:" prompt and press <RETURN>.

The name of the user logged into the system and the program defaults based on your initial selection of default values will be displayed.

Enter PRIMARY PROVIDER: ADAM,ADAM// <RETURN>

- Type the name of the primary provider (if the provider is different than the default) next to the "Enter Primary Provider:" prompt and press <RETURN>.

OR

- Press <RETURN> at the "Enter Primary Provider:" prompt to accept the default provider listed, as displayed above.

The Mental Health/Social Services Record Update Screen will be displayed.

* MENTAL HEALTH/SOCIAL SERVICES RECORD UPDATE *

Encounter Date: APR 24,1997 User: JONES,SUE

PROGRAM: MENTAL HEALTH
LOCATION OF ENCOUNTER: ALBUQUERQUE HOSPITAL
FLAG FIELD:
Any SECONDARY PROVIDERS? N
COMMUNITY OF SERVICE: ALBUQUERQUE
ACTIVITY CODE:
SERVED: 1
ACTIVITY TIME:
TYPE OF CONTACT:
LOCAL SERVICE SITE:
PURPOSE OF VISIT (POVS) <hit return>:
COMMENT:

Mental Health/Social Services Record Update Screen

NOTE: The encounter date you entered when you selected the SDE option will be displayed as the default encounter date on the screen. If you need to change the encounter date, exit from the record list to return to the Encounter Date prompt. Enter the new date to continue.

- Type data on this screen in the same manner that you added a patient record (see Section 2.1.1, Add a Patient Record directly above). The screen for POVs is the same as that used when you add a patient record.

2.1.3 Edit Record

- To modify a patient or activity record, type “ED” at the “Select Action:” prompt in the Update MH/SS Forms Screen and press <RETURN>.
- If more than one patient or activity record has been entered for the date you selected, type the number of the record you want to edit next to the “Select MHSS Activity Records:” prompt and press <RETURN>.

The Mental Health/Social Services Record Edit Screen will be displayed. The screens for editing a record are almost the same as those used when you add a patient record (see Section 2.1.1, Add a Patient Visit, above). The Mental Health/Social Services Record Edit Screen, however, does give you the option to edit primary and secondary providers. This option is detailed below.

* MENTAL HEALTH/SOCIAL SERVICES RECORD EDIT *		
Encounter Date: APR 24,1997	User: JONES,SUE	
Patient Name: WILSON,JIMMY	DOB: 1/2/50	HRN: 59294

<u>Date:</u> APR 24,1997	<u>Patient:</u> WILSON,JIMMY	
<u>Program:</u> MENTAL HEALTH	<u>Location of Service:</u> ALABAMA/COUSHATTA HE	
<u>Clinic:</u> FAMILY PLANNING	<u>Outside Location:</u> None	
<u>Appt/Walk-in:</u> UNSPECIFIED	<u>Flag:</u> 7	
<u>Providers <hit return>:</u>	<u>Evaluation&Management CPT:</u> 99211	
<u>Local Service Site:</u>		
<u>Community:</u> MILES	<u>#Served:</u> 3	<u>Activity Time:</u> 3
<u>Activity:</u> 13	<u>Type of Contact:</u> FIELD	
<u>Purpose of Visit (POVS) <hit return>:</u>		
<u>Comment:</u> None		
<u>Any Patient Education to Enter/Edit? :</u> N		
<u>NEXT SCREEN (hit return for more fields to edit):</u>		

Mental Health/Social Services Record Edit Screen

- **Providers.** When you press <RETURN> at the "Provider:" prompt above, the "Enter/Edit Providers of Service" Screen will be displayed.

```
***** ENTER/EDIT PROVIDERS OF SERVICE *****  
  
Encounter Date: APR 24,1997@12:00   User: JONES,SUE  
Patient Name: WILSON,JIMMY  
-----  
PROVIDER: ADAM,ADAM           PRIMARY/SECONDARY: PRIMARY  
PROVIDER: WHITT,HORACE M     PRIMARY/SECONDARY: SECONDARY  
PROVIDER:                    PRIMARY/SECONDARY:  
PROVIDER:                    PRIMARY/SECONDARY:  
PROVIDER:                    PRIMARY/SECONDARY:  
PROVIDER:                    PRIMARY/SECONDARY:
```

Enter/Edit Providers of Service Screen

- Type the name of the provider next to the "Provider:" prompt and press <RETURN>.
- Type whether the provider is primary or secondary next to the "Primary/Secondary:" prompt and press <RETURN> to record your entry.
- Press <RETURN> at the "Next Screen:" prompt at the bottom of the Mental Health/Social Services Record Edit Screen to access additional data entry screens.

The Enter/Edit Patient Information Screen and the Mental Health/Social Services Record Edit Screen and their subscreens will be displayed. These screens are detailed in Section 2.1.1, Add a Patient Visit, above.

2.1.4 Update Patient Information

Use this option to update or append information on a patient encounter record.

- To update or append a patient record, type "AP" at the "Select Action:" prompt in the Update MH/SS Forms Screen and press <RETURN>.

- Type the number of the activity record you want to update next to the “Select MHSS Activity Records:” prompt and press <RETURN>.

The Other Information Screen will be displayed. This screen lists the types of patient data you may update, add, or edit. Each of the options in the Other Information Screen below are detailed in the following subsections.

```
***** OTHER INFORMATION *****  
  
Update, add or append any of the following data  
  1). Update any of the following information:  
     Designated Providers, Patient Flag  
  2). Patient Case Open/Admit/Closed Data  
  3). MHSS Patient Diagnosis List  
  4). Enter Local Service Site  
  5). Personal History Information  
  6). Print an Encounter Form  
  7). None of the Above (Quit)  
Choose one of the above: (1-7): 7//4 <RETURN>  
  
LOCAL SERVICE SITE:
```

Other Information Screen

2.1.4.1 Update Information (Designated Providers, Patient Flag)

Use this option to modify any designated providers to which a patient has been assigned as well as the local flag field and narration. Designated providers and local flags are optional data items and are not used at all sites. If you use these fields, this option provides a way to change any of the entries using the screen shown below.

- To update provider information or patient flag information, type "1" at the prompt in the Other Information Screen and press <RETURN>.

The Update Patient Information Screen will be displayed.

```
***** UPDATE PATIENT INFORMATION *****  
  
Patient Name: WILSON,JIMMY  
-----  
DESIGNATED MENTAL HEALTH PROVIDER: DOUGLAS,BILL  
DESIGNATED SOCIAL SERVICES PROVIDER: BUTCHER,LORI  
OTHER DESIGNATED PROVIDER: MASON,BILL  
=====
```

PATIENT FLAG FIELD:
PATIENT FLAG NARRATIVE:

Exit Save Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

Save changes before leaving form (Y/N)? Press <PF1>H for help

Update Patient Information Screen

- To change or add the name of the Mental Health, the Social Services, or another Designated Provider, type the name of the provider next to the correct prompt and press <RETURN> to record your changes, as displayed above.
- To change or add patient flag information, type the new information next to the correct prompts and press <RETURN> to record your changes
- To exit the screen, type "E" (Exit) at the "Command" prompt and press <RETURN>.
- To save your changes, type "Y" (Yes) next to the "Save changes before leaving form (Y/N)?" prompt and press <RETURN> to redisplay the Other Information Screen.

2.1.4.2 Patient Case Open/Admit/Closed Data

- To edit information related to a selected patient's case, type "2" at the prompt in the Other Information Screen and press <RETURN>.

The Update MHSS Patient Case Data Screen will be displayed.

Update MHSS Patient Case Data Feb 24, 1997 09:42:43		Page: 1 of 1

Patient Name: WILSON,JIMMY DOB: JAN 01, 1933 Sex: F HRN: 256		

#	PROGRAM	OPEN ADMIT CLOSED DISPOSITION PROVIDER
1	MENTAL	2/13/97 2/13/97 ADAM,ADAM
	Primary Problem: 18 ANXIETY DISORDER	Next Review: 2/20/97
?? for more actions + next screen - prev screen		
OP	Open New Case	ED Edit Case Data Q Quit
Select Item(s): Quit//		

Update MHSS Patient Case Data

Open New Case

- To open a new case, type "OP" at the "Select Item(s):" prompt and press <RETURN>.

The screen below will be displayed.

Opening a Case for WILSON,JIMMY
Enter CASE OPEN DATE: April 24, 1997 (APR 24, 1997)
Creating new case...

- Type the date you want to open the case next to the "Enter Case Open Date:" prompt and press <RETURN>.

The Update Patient Case Data Screen will be displayed.

```
***** UPDATE PATIENT CASE DATA *****
Patient Name: WILSON,JIMMY
*****
CASE OPEN DATE: APR 30,1997 <RETURN>
PROGRAM AFFILIATION:
PROVIDER NAME:
CASE ADMIT DATE:

DATE CASE CLOSED:
DISPOSITION:

PRIMARY PROBLEM:
NEXT CASE REVIEW DATE:

COMMENT: Patient has shown improvement.

Exit Save Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: Press <PF1>H for help
```

Update Patient Case Data Screen

- To open a case, complete the information as prompted and press <RETURN> after each prompt to record your entry.
- To view a list of available entries, type "???" after the prompt and press <RETURN> (e.g., to view a list of available dispositions, type "???" after the "Disposition:" prompt and press <RETURN>. The screen below will be displayed).

```
Choose from:
ADMINISTRATIVE TERMINATION 4
COMPLETED TREATMENT, STABLE 1
MUTUAL AGREEMENT TO TERMINATE 3
OTHER 8
PATIENT DIED 7
PATIENT DROPPED OUT OF TREATME 5
PATIENT MOVED 6
REFERRED TO OTHER SOURCE 2
```

NOTE: The case open date and program affiliation are required fields that must be completed before the data can be filed. If you attempt to save your entry before you complete one of these fields, the following screen will be displayed.

THE DATA COULD NOT BE FILED.
Page 1, PROGRAM AFFILIATION is a required field
Press RETURN to continue:

Edit Case Data

- To change or update the existing case data, type “ED” at the “Select Item(s)” prompt and press <RETURN>.

The Update Patient Case Data Screen will be displayed. The screen will look the same as the Update Patient Case Data Screen in the Open New Case section directly above.

- Press <RETURN> to advance to the entry (prompt) you want to update or revise.
- Type the revision or update at the prompt and press <RETURN> to record your changes.
- To view a list of available entries, type “??” after the prompt and press <RETURN> (see Open New Case section directly above for an example).
- When you finish entering the revisions, type “S” (Save) at the “Command:” prompt and press <RETURN> to save your revisions.
- Type “E” (Exit) at the “Command:” prompt to return to the “Update MHSS Patient Case Data Screen.

2.1.4.3 MHSS Patient Diagnosis List

Use this option to modify items on both the patient’s Mental Health/Social Services and PCC problem lists. Use the Mental Health/Social Services Patient Diagnosis List Update Menu below to specify the action and the problem list.

NOTE: You may add (active and inactive) problems on the PCC list, but you must first go to the PCC. Items 1 through 9 in the Mental Health/Social Services Patient Diagnosis List Update Menu, below, can be used only in the Mental Health software.

- To update information related to a patient, type “3” at the prompt in the Other Information Screen and press <RETURN>.

The Mental Health/Social Services Patient Diagnosis List Update Menu will be displayed.

Mental Health/Social Services Patient Diagnosis List Update Menu

- 1) Add a Problem to MHSS Diagnosis List
- 2) Modify a Problem on MHSS Diagnosis List
- 3) Remove a Problem from MHSS Diagnosis List
- 4) Inactivate an Active Problem on MHSS Diagnosis List
- 5) Activate an Inactive Problem on MHSS Diagnosis List
- 6) Add a Treatment Note to a MHSS Problem
- 7) Modify a Treatment Note of MHSS Problem
- 8) Remove a Treatment Note to MHSS Problem
- 9) Display Patient's MHSS Diagnosis List
- 10) Display a Patient's PCC Problem List
- 11) Inactivate a PCC Problem
- 12) Activate a PCC Problem
- 13) Quit

Choose One: (1-13): 13//

Mental Health/Social Services Patient Diagnosis List Update Menu

Add a Problem to MH/SS Problem List

- To add a problem to a patient's record, type "1" at the "Choose One: (1-13):" prompt in the Patient Diagnosis List Update Menu and press <RETURN>.

The existing Mental Health/Social Services Diagnosis List for the patient you selected will be displayed.

MENTAL HEALTH/SOCIAL SERVICES Diagnosis List for WILSON,JIMMY

***** ACTIVE PROBLEMS AND TREATMENT NOTES/NOTES *****

1 04/24/97 (305.70) AMPHETAMINE ABUSE, UNSPECIFIED
Patient is working on problem. (ONSET: 05/01/96)

Enter PROBLEM DIAGNOSIS:

Mental Health/Social Services Diagnosis List Screen

- Type the name or number of the problem you want to add next to the "Enter Problem Diagnosis:" screen and press <RETURN>.

- To view a list of problems and their numbers, type “??” after the “Enter Problem Diagnosis:” prompt and press <RETURN>.

The “Provider Narrative:” prompt will be displayed.

```
Enter PROBLEM DIAGNOSIS: 98 EMPLOYEE ASSISTANCE PROGRAM
PROVIDER NARRATIVE: Getting assistance from EAP.
DATE OF ONSET: t (MAY 16, 1997)
STATUS: A// ACTIVE
```

```
Add TREATMENT NOTES? (Y/N) N//Y
```

```
Treatment Note #1
```

```
NARRATIVE: Getting assistance from EAP.
```

```
LONG/SHORT TERM TREATMENT: s SHORT
```

```
AUTHOR: JONES,SUE//
```

```
Add TREATMENT NOTES? (Y/N) N//
```

- Enter the information as requested at each prompt and press <RETURN>, as displayed above.

NOTE: If you enter treatment notes in the above screen, they will be displayed when you select Option 6, Add a Treatment Note to a MH/SS Problem, Option 7, Modify a Treatment Note of a MH/SS Problem, or Option 8, Remove a Treatment Note to MH/SS Problem in the Display Patient's MH/SS Diagnosis List in the Mental Health/Social Services Patient Diagnosis List Update Menu.

- Type “Y” (Yes) at the “Add this Problem to the PCC Problem List?:” prompt and press <RETURN> to add the problem you entered to the patient's file.

Modify a Problem on MH/SS Problem List

- To edit a problem on a patient's record, type "2" in the Mental Health/Social Services Patient Diagnosis List Update Menu and press <RETURN>.

The Mental Health/Social Services Diagnosis List for the patient record you selected will be displayed.

```
MENTAL HEALTH/SOCIAL SERVICES Diagnosis List for WILSON,JIMMY.

***** ACTIVE PROBLEMS AND TREATMENT NOTES/NOTES *****

1  04/24/97 (305.70) AMPHETAMINE ABUSE, UNSPECIFIED
    Patient is working on problem. (ONSET: 05/01/96)

2  04/24/97 (305.63) COCAINE ABUSE, IN REMISSION
    Patient is making continual progress. (ONSET: 03/00/95)

**** INACTIVE PROBLEMS AND TREATMENT NOTES/NOTES ****

3  04/24/97 (92)   VOCATIONAL REHABILITATION
    None. (ONSET: 05/15/97)

Enter MH/SS Problem Number:
```

Mental Health/Social Services Diagnosis List

- Type the problem number you want to edit next to the "Enter MH/SS Problem Number:" prompt and press <RETURN>.

```
Enter MH/SS Problem Number: 3 92   WILSON,JIMMY   1546   3
VOCATIONAL REHABILITATION
PROBLEM CODE: 92//
PROVIDER NARRATIVE: None.// Patient is being treated.
STATUS: INACTIVE// Active ACTIVE
DATE OF ONSET: MAY 15,1997//
```

- Type your updates at the prompts and press <RETURN> after each prompt to record your changes, as displayed above.

Remove a Problem from MH/SS Problem List

- To delete a problem on a patient's record, type "3" in the Patient Diagnosis List Update Menu and press <RETURN>.

The Mental Health/Social Services Diagnosis List for the patient record you selected will be displayed (see the Modify a Problem on MH/SS Problem List section above).

- Type the number of the problem you want to delete next to the "Enter MH/SS Problem Number:" prompt and press <RETURN>.

```
Enter MH/SS Problem Number: 2
Are you sure that you want to remove MH/SS Problem Number 2? (Y/N) Y
Removing all Treatment Plans
Removing MH/SS Problem 2 ...
```

- Type "Y" (Yes) next to the "Are you sure you want to remove MH/SS Problem Number ___? (Y/N)" prompt to delete the problem number you selected, and press <RETURN>.

A confirmation message will be displayed.

Inactivate an Active Problem on MH/SS Problem List

- To inactivate a currently active problem on a patient's record, type "4" in the Patient Diagnosis List Update Menu and press <RETURN>.

The Mental Health/Social Services Diagnosis List for the patient record you selected will be displayed (see the Modify a Problem on MH/SS Problem List section above).

- Type the number of the problem you want to inactivate next to the "Enter MH/SS Problem Number:" prompt and press <RETURN>.

The problem number you entered will be placed on the Inactive List.

Activate an Inactive Problem on MH/SS Problem List

- To activate a currently inactive problem on a patient's record, type "5" in the Patient Diagnosis List Update Menu and press <RETURN>.

The Mental Health/Social Services Diagnosis List for the patient record you selected will be displayed (see the Modify a Problem on MH/SS Problem List section above).

- Type the number of the problem you want to activate next to the "Enter MH/SS Problem Number:" prompt and press <RETURN>.

The problem number you entered will be placed on the Active List.

Add a Treatment Note to a MH/SS Problem

- To add a treatment note to a problem on a patient's record, type "6" in the Patient Diagnosis List Update Menu and press <RETURN>.

The Mental Health/Social Services Diagnosis List for the patient record you selected will be displayed (see the Modify a Problem on MH/SS Problem List section above).

- Type the number of the problem to which you want to add a treatment note next to the "Enter MH/SS Problem Number:" prompt and press <RETURN>.

Enter MH/SS Problem Number: 3
Treatment Note #1
NARRATIVE: Patient is making progress.
LONG/SHORT TERM TREATMENT: Long LONG
AUTHOR: JONES,SUE//

- Type information as requested at the prompts and press <RETURN> after each prompt to record your entry, as displayed above (see Section 2.9, Update a Treatment Plan, for more information on adding treatment notes).

The treatment notes you entered above will be added to the patient's record, as displayed below.

```
MENTAL HEALTH/SOCIAL SERVICES Diagnosis List for WILSON,JIMMY.  
***** ACTIVE PROBLEMS AND TREATMENT NOTES/NOTES *****  
  
3 04/24/97 (92) VOCATIONAL REHABILITATION  
Patient is being treated. (ONSET: 05/15/97)  
3-1 LTP 04/24/97 Patient is making progress.
```

Modify a Treatment Note of MHSS Problem

- To modify a treatment note on a patient's record, type "7" in the Patient Diagnosis List Update Menu and press <RETURN>.

The Mental Health/Social Services Diagnosis List for the patient record you selected will be displayed (see the Modify a Problem on MH/SS Problem List section above).

- Type the number of the problem whose treatment note you want to modify next to the "Enter MH/SS Problem Number:" prompt and press <RETURN>.
- Type the number of the treatment note you want to modify (sometimes there is more than one treatment note in the patient record you selected) next to the "Enter Treatment Plan to Modify:" prompt and press <RETURN>.
- Type information as requested at the prompts and press <RETURN> after each prompt to record your entry.

NOTE: To change the Narrative, type the text you want to change after "Replace," and press <RETURN>. Type the new text you want to insert after "With", and press <RETURN>. Press <RETURN> after "Replace" to record your changes (see screen below).

```
Enter MH/SS Problem Number: 3  
Enter Treatment Plan to Modify: 1  
NARRATIVE: Patient is making progress. Replace is making With is not making  
Replace  
Patient is not making progress.  
AUTHOR: JONES,SUE//  
LONG/SHORT TERM TREATMENT: LONG//
```

Remove a Treatment Note to MH/SS Problem

- To delete a treatment note on a patient's record, type "8" in the Patient Diagnosis List Update Menu and press <RETURN>.

The Mental Health/Social Services Diagnosis List for the patient record you selected will be displayed (see the Modify a Problem on MH/SS Problem List section above).

- Type the number of the problem whose treatment note you want to delete next to the "Enter MH/SS Problem Number:" prompt and press <RETURN>.

Enter MH/SS Problem Number: 3 Enter Treatment Plan to REMOVE: 1 Are you sure you want to remove Treatment Plan Number 3? (Y/N) Y

- Type the number of the treatment note you want to delete (sometimes there is more than one treatment note in the patient record you selected) next to the "Enter Treatment Plan to Remove:" prompt and press <RETURN>.
- Type "Y" (Yes) next to the "Are you sure you want to remove Treatment Plan Number ___? (Y/N)" prompt to delete the treatment plan number you selected, and press <RETURN>.

A confirmation message will be displayed.

Display Patient's MH/SS Problem List

- To display a selected patient's problem list, type "9" in the Patient Diagnosis List Update Menu and press <RETURN>.

The Mental Health/Social Services Diagnosis List for the patient record you selected will be displayed.

Display a Patient's PCC Problem List

- To review a selected patient's PCC problem list, type "10" in the Mental Health/Social Services Patient Diagnosis List Update Menu and press <RETURN>.

The PCC Problem List for the patient record you selected will be displayed.

The PCC Problem List displays the narrative the rest of the medical community will see on the Health Summary. The problem was created when you added a new problem to the patient's list in the Add a Problem to the MH/SS Diagnosis Screen.

```
PCC Problem List for WILSON,JIMMY.

***** ACTIVE PROBLEMS AND NOTES *****

SE16 05/29/96 HYPERTENSION
TI1 08/06/86 DIABETES MELLITUS TYPE II, ORAL MED (ONSET: 06/23/83)
TI2 01/05/97 DEPRESSION NOS

***** INACTIVE PROBLEMS AND NOTES *****

TI3 11/14/91 CODEINE INTOLERANCE

Press any key to continue
```

PCC Problem List Screen

Inactivate a PCC Problem

- To inactivate a problem on a selected patient's PCC problem list, type "11" in the Mental Health/Social Services Patient Diagnosis List Update Menu and press <RETURN>.

The PCC Problem List for the patient record you selected will be displayed.

- Type the number of the active problem you want to inactivate next to the "Enter Problem Number:" prompt and press <RETURN>, as displayed below.

The problem you selected will be automatically placed on the inactive problem list.

```
PCC Problem List for WILSON,JIMMY.
***** ACTIVE PROBLEMS AND NOTES *****
AH1    04/24/97 Patient is working on problem. (ONSET: 05/01/96)

***** No INACTIVE Problems on file for this Patient*****
Press any key to continue
Enter Problem Number: AH1

Inactivating Problem AH1 ...
```

PCC Problem List for a Selected Patient

Activate a PCC Problem

- To activate a problem on a selected patient's PCC problem list, type "12" in the Mental Health/Social Services Patient Diagnosis List Update Menu and press <RETURN>.

The PCC Problem List for the patient record you selected will be displayed.

- Type the number of the inactive problem you want to activate next to the "Enter Problem Number:" prompt and press <RETURN>, as displayed below.

The problem you selected will be automatically placed on the active problem list.

```
PCC Problem List for WILSON,JIMMY.
***** No ACTIVE Problems on file for this Patient*****

***** INACTIVE PROBLEMS AND NOTES *****
AH1    04/24/97 Patient is working on problem. (ONSET: 05/01/96)

Press any key to continue
Enter Problem Number: AH1

Activating Problem AH1 ...
```

PCC Problem List for Selected Patient

Quit

- To exit the Patient Diagnosis List Update Menu, type “13” at the “Choose One (1-13):” prompt and press <RETURN>.

The Other Information Screen will be displayed.

2.1.4.4 Enter Local Service Site

- To enter the local service site, type “4” at the “Choose one of the above: (1-7):” prompt in the Other Information Menu and press <RETURN>.

The “Local Service Site:” prompt will be displayed.

- Type the name of the local service site next to the “Local Service Site:” prompt and press <RETURN>.

2.1.4.5 Personal History Information

- To add, change, or delete any personal history items from a patient’s MH/SS record, type “5” at the “Choose one of the above: (1-7):” prompt in the Other Information Menu and press <RETURN>.

The “Enter Personal History:” prompt will be displayed.

```
***** PERSONAL HISTORY FOR WILSON,JIMMY*****  
  
05/16/97  SUBSTANCE ABUSE  
05/19/97  PARTNER ABUSE (VICTIM)  
Enter PERSONAL HISTORY:
```

Personal History for a Selected Patient

Add a Personal History Item

- Type the personal history item you want to add next to the “Personal History:” prompt and press <RETURN>.

The item you typed will be added to the patient’s personal history record.

- To view a list of available personal history items, type “?” at the “Enter Personal History:” prompt and press <RETURN>.

The list below will be displayed.

```
Choose from:
CHILD ABUSE (VICTIM)
PARTNER ABUSE (VICTIM)
SUBSTANCE ABUSE
SUICIDE ATTEMPT

Enter PERSONAL HISTORY:
```

Change a Personal History Item

- Type the personal history item you want to change next to the “Personal History:” prompt and press <RETURN>.

You will be informed that the item you entered has already been recorded, as displayed below.

```
***** PERSONAL HISTORY FOR WILSON,JIMMY*****
05/16/97 SUBSTANCE ABUSE
05/19/97 PARTNER ABUSE (VICTIM)
Enter PERSONAL HISTORY: Partner Abuse (Victim)

PARTNER ABUSE (VICTIM) already recorded for this patient.
You may change it or delete it. To delete an entry, enter an '@'.

FACTOR: PARTNER ABUSE (VICTIM)// Child Abuse (Victim)
DATE ADDED: MAY 19,1997//
```

Personal History for a Selected Patient

- Type any replacement text at the “Factor:” prompt and press <RETURN> to record your entry.

OR

- Press <RETURN> to keep the current entry.

The “Date Added:” prompt will display the current date.

- Press <RETURN> to accept the current date.

OR

- Type a different date next to the “Date Added:” prompt and press <RETURN>.

Delete a Personal History Item

- Type the personal history item you want to delete next to the “Personal History:” prompt and press <RETURN>.

You will be informed that the item you entered has already been recorded, as displayed in the Change a Personal History Item subsection above.

- Type “@” at the “Factor:” prompt and press <RETURN>, as displayed below.
- Type “Y” (Yes) at the “Sure You Want to Delete the Entire MH/SS Patient Personal HX?” prompt and press <RETURN> to delete the selected personal history item.

FACTOR: CHILD ABUSE (VICTIM)// @ SURE YOU WANT TO DELETE THE ENTIRE MHSS PATIENT PERSONAL HX? Y (Yes)
--

OR

- Press <RETURN> to keep the current entry.

2.1.4.6 Print an Encounter Form

- To print a patient encounter form, type "6" at the "Choose one of the above: (1-7):" prompt in the Other Information Menu and press <RETURN>.

The following screen will be displayed. You may print a Full Encounter Form, a Suppressed Encounter Form, or both. These forms are detailed below.

Select one of the following: F Full Encounter Form S Suppress Subjective/Objective/Chief Complaint Encounter Form B Both a Suppressed&Full T 2 copies of the Suppressed E 2 copies of the Full What type of form do you want to print: B// <RETURN> DEVICE: HOME// <RETURN>
--

Full Encounter Form

A Full Encounter Form lists the patient's Chief Complaint, but not the primary mental health or social services contact's comments (Subjective/Objective), as displayed below.

CHIEF COMPLAINT: Depression SUBJECTIVE/OBJECTIVE:
--

Suppress Subjective/Objective/Chief Complaint Encounter Form

A Suppress Encounter Form will not print the patient's Chief Complaint. This form will refer you to the patient's primary mental health or social services contact for details of the patient's problem (Subjective/Objective), as displayed below.

CHIEF COMPLAINT: Chief Complaint Suppressed for Confidentiality SUBJECTIVE/OBJECTIVE: Mental Health or Social Services Contact See ADAM,ADAM for details.

NOTE: To view the primary mental health or social services contact's comments (Subjective/Objective), go to the Display Record option in the Update MH/SS Forms Screen.

- Type the corresponding letter of the type of form you want to print next to the "What type of form do you want to print:" prompt and press <RETURN>.
- Type a print device at the "Device:" prompt and press <RETURN>.

The PCC Mental Health/Social Services Encounter Record for the selected patient record will print, as displayed below.

***** CONFIDENTIAL PATIENT INFORMATION ***** PCC MENTAL HEALTH/SOCIAL SERVICES ENCOUNTER RECORD *** Computer Generated Encounter Record *** *****			
Date: APR 24, 1997		Primary Provider: ADAM,ADAM	
Arrival Time:			
Program:			
Clinic:			
Appointment Type:			
Community:	Activity:	Number Served:	Activity/Service Time:
	Type of Contact:		
CHIEF COMPLAINT: Chief Complaint Suppressed for Confidentiality SUBJECTIVE/OBJECTIVE: Mental Health or Social Services Contact See ADAM,ADAM for details.			
Enter RETURN to continue or '^' to exit:			

MH/SS POV CODE	PURPOSE OF VISIT (POV)
OR DSM DIAGNOSIS	[PRIMARY ON FIRST LINE]
TREATED MEDICAL PROBLEMS:	
MEDICATIONS PRESCRIBED:	
PROCEDURES (CPT):	
COMMENT:	
Enter RETURN to continue or '^' to exit:	

HR#: 59294	SSN: 333882211
NAME: WILSON,JIMMY	
SEX: MALE	TRIBE: COUSHATTA TRIBES OF TEXAS
DOB: JAN 02, 1950	
RESIDENCE: TESUQUE	
FACILITY: ALBUQUERQUE HOSPITAL LOCATION:	
PROVIDER SIGNATURE:	

Enter RETURN to continue or '^' to exit:	

PCC Mental Health/Social Services Encounter Record

- Press <RETURN> at the “Enter Return to continue or ‘^’ to exit” prompts at the bottom of each screen to view the next screen.

2.1.4.7 None of the Above (Quit)

- To exit the Other Information Menu, type “7” at the “Choose one of the above: (1-7):” prompt in the Other Information Menu and press <RETURN>.

The Update MH/SS Forms will be displayed.

2.1.5 Display Record

- To display information on a Mental Health/Social Services record, type “DS” at the “Select Action:” prompt in the Update MH/SS Forms Screen and press <RETURN>.

- Type the number of the activity record you want to display next to the "Select MHSS Activity Records:" prompt and press <RETURN>.

The MHSS Visit Record Display Screen for the selected patient record will be displayed. Keep pressing <RETURN> to advance to the next screen.

```
MHSS VISIT RECORD DISPLAY   May 20, 1997 10:42:44   Page:  1 of  3

Patient Name:  WILSON,JIMMY
Chart #:       None
Date of Birth: JUL 30, 1953
Sex:          M
===== MHSS RECORD FILE =====
DATE OF SERVICE:          APR 24, 1997@12:00
PROGRAM:                  MENTAL HEALTH
POSTING DATE:             MAY 07, 1997
LOCATION OF ENCOUNTER:     ALBUQUERQUE HOSPITAL
COMMUNITY OF SERVICE:    ALBUQUERQUE
ACTIVITY TYPE:           24
TYPE OF CONTACT:         OUTPATIENT CLINIC
PATIENT:                 WILSON,JIMMY
PT AGE:                  43
NUMBER SERVED:           1
APPT/WALK-IN:           APPOINTMENT
ACTIVITY TIME:           4
INTERPRETER UTILIZED:    NO
PLACEMENT DISPOSITION:   IHS HOSPITAL
WHO ENTERED RECORD:     JONES,SUE
DATE LAST MODIFIED:     MAY 15, 1997
CLINIC:                  MENTAL HEALTH
USER LAST UPDATE:       JONES,SUE
CHIEF COMPLAINT:        Depression
AXIS IV:
SUBJECTIVE/OBJECTIVE:
Patient depressed at regular intervals.
MEDICATIONS PRESCRIBED:
None
===== MHSS RECORD PROVIDERS =====
PROVIDER:                 ADAM,ADAM
PROVIDER DISCIPLINE:     LABORATORY TECHNICIAN
PRIMARY/SECONDARY:       PRIMARY
===== MHSS RECORD PROCEDURES (CPT) =====
CPT CODE:                30020
CPT CODE NARRATIVE:      DRAINAGE OF NOSE LESION

Enter ?? for more actions
+ Next Screen   - Previous Screen   Q Quit
Select Action: +//
```

MHSS Visit Record Display Screen

- To advance to the second screen of the MHSS Visit Record Display, type “+” at the “Select Action:” prompt and press <RETURN>.
- To go back to the first screen of the MHSS Visit Record Display, type “-“ at the “Select Action:” prompt and press <RETURN>.
- To return to the Update MH/SS Forms Screen, type “Q” (Quit) and press <RETURN>.
- To view more options, type “??” at the “Select Action:” prompt and press <RETURN>.

The following options (actions) will be displayed.

The following actions are also available:			
+ Next Screen	FS First Screen	SL Search List	
- Previous Screen	LS Last Screen	ADPL Auto Display(On/Off)	
UP Up a Line	GO Go to Page	QU Quit	
DN Down a Line	RD Re Display Screen		
> Shift View to Right	PS Print Screen		
< Shift View to Left	PL Print List		
Enter RETURN to continue or '^' to exit:			

- To use one of the above options, press <RETURN> at the “Enter RETURN to continue or “^” to exit:” prompt.
- Enter the option you want next to the “Select Action:” prompt and press <RETURN>.
- Enter the information requested at each prompt.

2.1.6 Delete Record

- To delete a Mental Health/Social Services record, type “DE” at the “Select Action:” prompt in the Update MH/SS Forms Screen and press <RETURN>.
- Type the number of the activity record you want to delete next to the “Select MHSS Activity Records:” prompt and press <RETURN>.

A Confidential Patient Information Screen on the selected patient record will be displayed.

```
***** CONFIDENTIAL PATIENT INFORMATION *****  
-----  
----- MH/SS RECORD -----  
DATE OF SERVICE: APR 24, 1997@12:00      PROGRAM: MENTAL HEALTH  
POSTING DATE: APR 24, 1997  
LOCATION OF ENCOUNTER: ALBUQUERQUE HOSPITAL  
COMMUNITY OF SERVICE: ALBUQUERQUE ACTIVITY TYPE: 31  
TYPE OF CONTACT: OUTPATIENT CLINIC PATIENT: WILSON,JIMMY  
NUMBER SERVED: 1                          APPT/WALK-IN: APPOINTMENT  
ACTIVITY TIME: 4                          WHO ENTERED RECORD: JONES,SUE  
DATE LAST MODIFIED: MAY 01, 1997        EXTRACT FLAG: ADD  
CLINIC: MENTAL HEALTH                    USER LAST UPDATE: JONES,SUE  
CHIEF COMPLAINT: Migraine  
DATE/TIME EDITED: APR 24, 1997@16:40    WHO EDITED: JONES,SUE  
DATE/TIME EDITED: APR 24, 1997@16:42    WHO EDITED: JONES,SUE  
DATE/TIME EDITED: MAY 01, 1997@14:14    WHO EDITED: JONES,SUE  
DATE/TIME EDITED: MAY 01, 1997@14:28    WHO EDITED: JONES,SUE  
DATE/TIME EDITED: MAY 01, 1997@15:39    WHO EDITED: JONES,SUE  
Return to continue, '^' to halt <RETURN>
```

Confidential Patient Information Screen

- Press <RETURN> at the “Return to continue, ‘^’ to halt” prompt to advance to the next screen.

```
----- MHSS RECORD PROBLEMS (POVS) -----
PROBLEM CODE: 38                PATIENT: WILSON,JIMMY
MHSS RECORD: APR 24, 1997@12:00  PROVIDER NARRATIVE: None
PROBLEM CODE NARRATIVE (c): OTHER SUSPECTED MENTAL CONDITION
----- MHSS RECORD PROVIDERS -----
PROVIDER: ADAM,ADAM            PATIENT: WILSON,JIMMY
MHSS RECORD: APR 24, 1997@12:00  PRIMARY/SECONDARY: PRIMARY
PROVIDER DISCIPLINE (c): LABORATORY TECHNICIAN
PROVIDER: WHITT,HORACE M       PATIENT: WILSON,JIMMY
MHSS RECORD: APR 24, 1997@12:00  PRIMARY/SECONDARY: SECONDARY
PROVIDER DISCIPLINE (c): DENTIST
~~~~~

End of record display, press <RETURN> to continue: <RETURN>

Are you sure you want to DELETE this record? N//
```

Confidential Patient Information Screen

- Press <RETURN> at the “End of record display, press <RETURN> to continue:” prompt.
- To delete the patient record displayed, type “Y” (Yes) at the “Are you sure you want to Delete this record?” prompt and press <RETURN>.

OR

- If you do **not** want to delete the patient record displayed, type “N” (No) at the “Are you sure you want to Delete this record?” prompt and press <RETURN>.

2.1.7 Print Encounter Record

- To print a patient encounter record, type “PE” at the “Select Action:” prompt in the Update MH/SS Forms Screen and press <RETURN>.
- Type the number of the patient encounter record you want to print next to the “Select MHSS Activity Records:” prompt and press <RETURN>.

The following screen will be displayed. You may print a Full Encounter Form, a Suppressed Encounter Form, or both. These forms are detailed below.

```
Select one of the following:

F Full Encounter Form
S Suppress Subjective/Objective/Chief Complaint Encounter Form
B Both a Suppressed&Full
T 2 copies of the Suppressed
E 2 copies of the Full

What type of form do you want to print: B// <RETURN>

DEVICE: HOME// <RETURN>
```

Full Encounter Form

A Full Encounter Form lists the patient's Chief Complaint, but not the primary mental health or social services contact's comments (Subjective/Objective), as displayed below.

```
CHIEF COMPLAINT: Depression

SUBJECTIVE/OBJECTIVE:
```

Suppress Subjective/Objective/Chief Complaint Encounter Form

A Suppress Encounter Form will not print the patient's Chief Complaint. This form will refer you to the patient's primary mental health or social services contact for details of the patient's problem (Subjective/Objective), as displayed below.

<p>CHIEF COMPLAINT: Chief Complaint Suppressed for Confidentiality</p> <p>SUBJECTIVE/OBJECTIVE: Mental Health or Social Services Contact See ADAM,ADAM for details.</p>

NOTE: To view the primary mental health or social services contact's comments (Subjective/Objective), go to the Display Record option in the Update MH/SS Forms Screen.

- Type the corresponding letter of the type of form you want to print next to the "What type of form do you want to print:" prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The PCC Mental Health/Social Services Encounter Record for the selected patient record will print, as displayed below.

***** CONFIDENTIAL PATIENT INFORMATION ***** PCC MENTAL HEALTH/SOCIAL SERVICES ENCOUNTER RECORD *** Computer Generated Encounter Record *** *****			
Date: APR 24, 1997		Primary Provider: ADAM,ADAM	
Arrival Time:			
Program:			
Clinic:			
Appointment Type:			
Community:	Activity:	Number Served:	Activity/Service Time:
	Type of Contact:		
CHIEF COMPLAINT: Chief Complaint Suppressed for Confidentiality			
SUBJECTIVE/OBJECTIVE: Mental Health or Social Services Contact See ADAM,ADAM for details.			
Enter RETURN to continue or '^' to exit:			

MH/SS POV CODE	PURPOSE OF VISIT (POV)
OR DSM DIAGNOSIS	[PRIMARY ON FIRST LINE]
TREATED MEDICAL PROBLEMS:	
MEDICATIONS PRESCRIBED:	
PROCEDURES (CPT):	
COMMENT:	
Enter RETURN to continue or '^' to exit:	

- Type the name, record number, Social Security Number, or date of birth of the patient whose health summary you want to view and press <RETURN>, as displayed above.

A PCC Health Summary (Output Browser Screen) for the patient you selected will be displayed.

```
OUTPUT BROWSER      May 07, 1997 10:40      Page:  1 of  3
PCC Health Summary for WILSON,JIMMY

*****
*****
-----
WILSON,JIMMY          DOB: JUL 30,1953  MALE  A+
CHEROKEE INDIANS, EASTERN BAND, N
(H) 505-890-3191      SSN: 131-41-3141
NORTH CAROLINA UNK (6912 LAMAR AVE
NW,ALBUQUERQUE,NM,87120)
LAST UPDATED: JUL 8,1996  ELIGIBILITY: CHS & DIRECT

HEALTH RECORD NUMBERS: 121212 ALBUQUERQUE HOSPITAL
PRINCIPAL PROVIDER: DOCTOR,B
-----
02/14/97-?  ALBUQUERQ HO <no visit data>
+   Enter ?? for more actions                >>>
+  NEXT SCREEN      -  PREVIOUS SCREEN      Q  QUIT
Select Action: +// <RETURN>
```

```
OUTPUT BROWSER      May 07, 1997 10:58:35      Page:  2  3
PCC Health Summary for WILSON,JIMMY
+
07/08/96-02/14/97 ALBUQ ADMIN <no visit data>
07/08/96-02/14/97 ALBUQUERQ HO <no visit data>
-----
04/24/97 ALBUQUER AA  OPC <MH/SS problem codes not yet entered>
+   Enter ?? for more actions                >>>
+  NEXT SCREEN      -  PREVIOUS SCREEN      Q  QUIT
Select Action: +// <RETURN>
```

PCC Health Summary Screen

- To advance to the second screen of the PCC Health Summary, type “+” at the “Select Action:” prompt and press <RETURN>.
- To go back to the first screen in the PCC Health Summary you selected, type “-“ at the Select Action:” prompt and press <RETURN>.

- To view more options, type “??” at the “Select Action:” prompt and press <RETURN>.

The following options (actions) will be displayed.

The following actions are also available:			
+ Next Screen	FS First Screen	SL Search List	
- Previous Screen	LS Last Screen	ADPLAuto Display(On/Off)	
UP Up a Line	GO Go to Page	QU Quit	
DN Down a Line	RD Re Display Screen		
> Shift View to Right	PS Print Screen		
< Shift View to Left	PL Print List		
Enter RETURN to continue or '^' to exit:			

- To use one of the above options, press <RETURN> at the “Enter RETURN to continue or “^” to exit:” prompt.
- Enter the option you want next to the “Select Action:” prompt and press <RETURN>.
- Enter the information requested at each prompt.
- To exit the PCC Health Summary Screen, type “Q” (Quit) at the “Select Action:” prompt and press <RETURN>.

2.1.9 SOAP/CC Edit

- To edit a patient’s chief complaint field and subjective/objective observations, type “SO” at the “Select Action:” prompt in the Update MH/SS Forms Screen and press <RETURN>.
- Type the number of the patient encounter record you want to edit next to the “Select MHSS Activity Records:” prompt and press <RETURN>.

The patient’s record you want to edit and the chief complaint and subjective/objective fields will be displayed in sequence.

You are editing the following record:						
#	PRV	PATIENT NAME	HRN	LOC	ACT	PROB NARRATIVE

7	AA	WILSON,JIMMY	AH121212	ALBUQUE	24	<No Problems recorded.>
CHIEF COMPLAINT: Depression//						
SUBJECTIVE/OBJECTIVE:						
1>Patient depressed at regular intervals.						
EDIT Option:						

- To edit the patient's chief complaint, type your changes next to the "Chief Complaint:" prompt and press <RETURN> to record your changes.
- To edit the subjective/objective observation field, do one of the following:
 - Type the first letter of the word processing command you want to use next to the "EDIT Option:" prompt and press <RETURN>.

NOTE: To list available word processing commands, type "???" after the "Edit Option:" prompt and press <RETURN>.

- Type your edits (changes) as prompted and press <RETURN>.

OR

- Type the line number you want to edit next to the "Edit Option:" prompt and press <RETURN>.

EDIT Option: 1 1>Patient depressed at regular intervals. Replace at regular With at normal Replace Patient depressed at normal intervals. Edit line:
--

- Type the text you want to change after "Replace," and press <RETURN>.
- Type the new text you want to insert after "With", and press <RETURN>.
- Press <RETURN> after "Replace" to record your changes.

2.1.10 Switch Dates

- To switch the Date of Encounter on the MH/SS Forms Screen from the date currently on the screen to a different date, type "SD" at the "Select Action:" prompt in the Update MH/SS Forms Screen and press <RETURN>.
- Type the Date of Encounter you want to view next to the "Enter Date:" prompt and press <RETURN>.

The Update MH/SS Forms Screen with the Encounter Date you entered will be displayed.

2.1.11 Search List

- To find a patient record for a particular encounter date, type “SL” at the “Select Action:” prompt in the Update MH/SS Forms Screen and press <RETURN>.

NOTE: Use this option if the list of records for an encounter date is extensive.

- Type the name (first or last), record number, or diagnosis for the patient record you are searching for next to the “Search for:” prompt and press <RETURN>.

The record identifier (name, record number, or diagnosis) you typed next to the “Search for:” prompt will be highlighted. If you keep pressing <RETURN>, any other identifiers like the one you typed at the “Search for:” prompt will also be highlighted.

2.1.12 Quit

- To exit the Update MH/SS Forms Screen, type “Q” (Quit) at the “Select Action:” prompt in the Update MH/SS Forms Screen and press <RETURN>.

The “Enter Encounter Date:” prompt will be displayed.

- Type the encounter date you want to display at the “Enter Encounter Date:” prompt and press <RETURN>.

OR

- Press <RETURN> at the “Enter Encounter Date:” prompt to display the MH/SS Main Screen.

2.2 Update MH/SS Encounter Data - Roll'N Scroll Mode

The roll-and-scroll data entry format captures the same information as the screen format but uses a series of prompts for recording data. This method is typically the most efficient for data entry staff to use. Adding, editing, deleting, and viewing patient and nonpatient records is essentially the same as the screen entry method.

- **To enter encounter data, type “RDE” at the prompt in the Data Entry Menu and press <RETURN>.**

The Update MH/SS Records Screen will be displayed.

```
MH/SS Data Entry Module
*****
* Update MH/SS Records *
*****

Please enter the appropriate set of defaults to be used in Data entry.
This applies to default clinic, location, community and program.

Select one of the following:
  M   MENTAL HEALTH DEFAULTS
  S   SOCIAL SERVICES DEFAULTS

Which set of defaults do you want to use in Data Entry: M

Enter ENCOUNTER DATE: TODAY
```

Update MH/SS Records Screen

- Type the letter of the default you want to edit next to the “Which set of defaults do you want to use in Data Entry:” prompt and press <RETURN>.
- Type the date for which you want to view records next to the “Enter Encounter Date:” prompt and press <RETURN>.

A selection list of records that have been entered for the encounter date will be displayed. If no records exist for that particular date, an indicating message will be displayed, as shown below. The available data entry actions are listed at the bottom of the screen. Each action is detailed in the following section(s).

At the bottom of the screen is the same set of action items that were present for the screen data entry. For instructions on using these action items, refer to the previous section that details the screen format data entry process.

Update MH/SS Forms	Feb 12, 1997 10:30:27	Page: 1 of

Date of Encounter: FEB 12, 1997		

No records currently on file for FEB 12, 1997		
?? for more actions + next screen - prev screen		
AV Add Patient Visit	DS Display Record	SO SOAP/CC Edit
AN Add Non Pat Record	DE Delete Record	SL Search List
ED Edit Record	PE Print Enc Record	Q Quit
AP Update Pat Info	HS Health Summary	
Select Action: AV//		

- To enter data, type the corresponding letters at the "Select Action:" prompt in the Update MH/SS Forms Screen and press <RETURN>.
- Type information as requested at each prompt in the Adding Patient Record Screen – Roll'N Scroll Mode and press <RETURN> after each response to record your entry.

NOTE: The default values are preset for use in cases where the response is likely to be the same each time a record is entered (e.g., the location name). If the default value is inaccurate, replace it with the correct entry. Each set of program defaults is assigned by your Site Manager using the Manager Utilities option. See your Site Manager to modify these defaults.

See Section 2.1 Update MH/SS Encounter Data – Screen Entry for details on each of the options in the Update MH/SS Forms Screen, above (since all the options listed above are identical to using the screen data entry actions).

A sample dialog for adding a patient record using the roll-and-scroll mode are displayed below to show how this process is different from the screen format data entry.

Date of Service: APR 24, 1997

Creating new record...

Program.....: M// MENTAL HEALTH
Location of Encounter....: ALBUQUERQUE HOSPITAL// ALBUQUERQUE
ALBUQUERQUE 01
Clinic.....: MENTAL HEALTH// 14
Appt/Walk-in/Unspec.....: APPOINTMENT// APPOINTMENT
Community of Service.....: ALBUQUERQUE// BERNALILLO NEW MEXICO 082 3501082
Activity Code.....: 33 TECHNICAL ASSISTANCE-PATIENT NOT PRESENT
Number Served.....: 1//
Activity/Service Time....: 4
Enter PRIMARY Provider...: ADAM,ADAM
Enter SECONDARY Provider.:
Flag Field (Local Use)...:
Type of Contact.....: OUTPATIENT CLINIC// 2
Arrival Time.....: 12:00// (APR 24, 1997@12:00)
Enter PRIMARY Problem-POV: 33
1 33 MILD MENTAL RETARDATION
2 333.90 MEDICATION-INDUCED MOVEMENT DISORDER NOS
3 332.1 332.1 NEUROLEPTIC-INDUCED PARKINSONISM
4 333.1 333.1 MEDICATION-INDUCED POSTURAL TREMOR
5 333.7 333.7 NEUROLEPTIC-INDUCED ACUTE DYSTONIA
TYPE '^' TO STOP, OR
CHOOSE 1-5: 4 333.1
Provider Narrative.....: NONE NONE
Enter ANOTHER Problem-POV:
EVALUATION & MANAGEMENT CPT: 99204 OFFICE/OUTPATIENT VISIT, NEW
OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF
A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A
...OK? Yes// (Yes)
Local Service Site....:

COMMENT:

Adding Patient Record Screen – Roll'N Scroll Mode

2.3 Patient Centered Data Entry

Use this option to edit/view encounter data on a specific patient. This option will be used most often by providers (to be completed after visiting with a patient). These options are basically the same as the options in Section 2.1, SDE – Update MH/SS Encounter Data – Screen Entry.

- To edit/view a specific type of encounter data on a patient's encounter record, type "PDE" at the prompt in the Data Entry Menu and press <RETURN>.

The "Select Patient Name:" prompt will be displayed.

```
Select PATIENT NAME: WILSON,JIMMY      M  08-15-95      AH 112696
Select HEALTH SUMMARY TYPE NAME:  DIABETES STANDARD//
```

- Type the name of the patient whose data you want to edit/view next to the "Select Patient Name:" prompt and press <RETURN>.
- Enter the type of health summary you want to view on the selected patient next to the "Select Health Summary Type Name:" prompt and press <RETURN>.

The type of health summary you select will determine what encounter data is displayed on the screen.

NOTE: To view a list of available health summary types, type "??" next to the "Select Health Summary Type Name:" prompt and press <RETURN>.

```
Choose from:
ADULT REGULAR
DENTAL
DIABETES STANDARD
IMMUNIZATION
MENTAL HEALTH/SOCIAL SERVICES
PATIENT MERGE (COMPLETE)
PEDIATRIC
PROBLEM LIST
SAMPLE
```

The View Patient Record Screen will be displayed (the DIABETES STANDARD HEALTH SUMMARY option is displayed below). Use the options at the bottom of this screen to edit/modify/etc., specific portions of a patient's record. These options are basically the same as the options detailed in Section 2.1, Update MH/SS Encounter Data – Screen Entry.

NOTE: Keep pressing <RETURN> at the end of each screen to advance to the next screen.

```

VIEW PATIENT RECORD      May 23, 1997 14:05:32      Page:  1 of  3

*****
*****
-----
WILSON,JIMMY           DOB: AUG 15,1995      MALE <no blood type>
INDIAN NON-TRIBAL MEMBER
<no phone numbers recorded>
SALEM
LAST UPDATED: JAN 31,1997  ELIGIBILITY: DIRECT ONLY

HEALTH RECORD NUMBERS: 112696  ALBUQUERQUE HOSPITAL
PRINCIPAL PROVIDER: <none identified>

ENT. MODIFIED
AH1    04/97 04/24/97  None. (onset 05/16/97)

-----
02/25/97-?           ALBUQUERQ HO  <no visit data>
02/18/97-02/19/97   ALBUQUERQ HO  None
                    none

-----
                    LAST           NEXT

HEIGHT                DUE NOW
WEIGHT                DUE NOW
TB SKIN TEST          DUE NOW
HCT/HGB               DUE NOW
URINALYSIS            08/14/00
DTP-1 & OPV-1 & MMR-1 & HIB  DUE NOW

***END *****
- Previous Screen  Q Quit  ?? for More Actions
1 Patient Contact Data      4 Update Case Data      7 Display Meds
2 Treatment Plan Update    5 PCC Visit Details     8 Appointments
3 Problem List Update      6 Last MHSS Visit      Q Quit
Select Action: +/-

```

View Patient Record Screen

2.3.1 Patient Contact Data

- To enter/edit/view information on a patient encounter, type "1" next to the "Select Action:" prompt in the View Patient Record Screen and press <RETURN>.

The Patient Contact/Visit Actions Available Menu will be displayed (see Section 2.1, Update MH/SS Encounter Data – Screen Entry, for information on how to use the six options in the menu below).

```
PATIENT CONTACT/VISIT ACTIONS AVAILABLE

1. ADD PATIENT CONTACT/VISIT
2. EDIT PATIENT CONTACT/VISIT
3. DISPLAY PATIENT CONTACT/VISIT
4. EDIT SOAP ON AN VISIT RECORD
5. DELETE PATIENT CONTACT/VISIT
6. PRINT ENCOUNTER FORM

Select Action by number: (1-6): 3

Enter ENCOUNTER DATE: APRIL24 (APR 24, 1997)
1  ADAM,ADAM                               AH 112696  56
2  ADAM,ADAM  AH  ALBUQUERQU 25 OUTP AH 112696  45.2
ABUSIVE BEHAVIO

Which record do you want to display: (1-2):
```

Patient Contact/Visit Actions Available Menu

- Type the number of the action you want to access next to the "Select Action by number: (1-6):" prompt and press <RETURN>.
- Type the encounter date of the patient record you want to view next to the "Enter Encounter Date:" prompt and press <RETURN>.

NOTE: If the patient has more than one encounter on the date you entered, type the number of the record you want to display next to the "Which record do you want to display:" prompt and press <RETURN> (see Patient Contact/Visit Actions Available Menu above).

2.3.2 Treatment Plan Update

- To update a patient's treatment plan (e.g., to record information on a patient encounter), type "2" next to the "Select Action:" prompt in the View Patient Record Screen and press <RETURN>.

The Update Patient Treatment Plan Screen will be displayed. Use the options at the bottom of the screen to add, edit, delete, or display/print a treatment plan.

```
Update Patient Treatment Plan May 27, 1997 11:13:29      Page:  1 of  1
Patient Name: WILSON,JIMMY  DOB: AUG 15, 1995  Sex: M
                TREATMENT PLANS CURRENTLY ON FILE

1) Date Established: MAY 22, 1997   Responsible Provider: <<not recorded>>
   Problem: <<not recorded>>
   Date Resolved:

        Enter ?? for more actions
AD  Add Treatment Plan RV  Enter TP Review   HS  Health Summary
ED  Edit a Plan           UG  Update a TP Goal  SL  Search List
DE  Delete Tx Plan       DS  Disp/Print Plan   Q   Quit

Select Action: AD//
```

Update Treatment Plan Screen

- Type the corresponding abbreviation of the action you want to access next to the "Select Action:" prompt and press <RETURN>.
- Type information as requested at the prompts and press <RETURN> to record your entries.

NOTE: The prompts will vary, depending on the action you select.

2.3.3 Problem List Update

- To modify items on both the patient's Mental Health/Social Services and PCC problem lists, type "3" at the "Select Action:" prompt in the View Patient Record Screen and press <RETURN>.

The Mental Health/Social Services Patient Diagnosis List Update Menu will be displayed. Each of the options in this menu is detailed in Section 2.1.4.3, MHSS Patient Diagnosis List.

Mental Health/Social Services Patient Diagnosis List Update Menu

- 1) Add a Problem to MHSS Diagnosis List
- 2) Modify a Problem on MHSS Diagnosis List
- 3) Remove a Problem from MHSS Diagnosis List
- 4) Inactivate an Active Problem on MHSS Diagnosis List
- 5) Activate an Inactive Problem on MHSS Diagnosis List
- 6) Add a Treatment Note to a MHSS Problem
- 7) Modify a Treatment Note of MHSS Problem
- 8) Remove a Treatment Note to MHSS Problem
- 9) Display Patient's MHSS Diagnosis List
- 10) Display a Patient's PCC Problem List
- 11) Inactivate a PCC Problem
- 12) Activate a PCC Problem
- 13) Quit

Choose One: (1-13): 13//

Mental Health/Social Services Patient Diagnosis List Update Menu

2.3.4 Update Case Data

- To edit information related to a selected patient's case or to open a new case on a selected patient, type "4" at the "Select Action:" prompt in the View Patient Record Screen and press <RETURN>.

The Update MH/SS Patient Case Data Screen will be displayed. The options in this screen are detailed in Section 2.1.4.2, Patient Case Open/Admit/Closed Data.

Update MHSS Patient Case Data Feb 24, 1997 09:42:43		Page: 1 of 1

Patient Name: WILSON,JIMMY DOB: JAN 01, 1933 Sex: M HRN: 256		

#	PROGRAM	OPEN ADMIT CLOSED DISPOSITION PROVIDER
1	MENTAL	2/13/97 2/13/97 ADAM,ADAM
	Primary Problem: 18 ANXIETY DISORDER	Next Review: 2/20/97
?? for more actions + next screen - prev screen		
OP	Open New Case	ED Edit Case Data Q Quit
Select Item(s): Quit//		

Update MH/SS Patient Case Data Screen

2.3.5 PCC Visit Details

- To view information from a specific patient encounter, type "5" at the "Select Action:" prompt in the View Patient Record Screen and press <RETURN>.

The "Enter Visit date:" prompt will be displayed.

Enter VISIT date:

- Type the date the encounter you want to view occurred at the "Enter Visit date:" prompt and press <RETURN>.

The View Patient Record Screen for the date you selected will be displayed. This screen is illustrated at the beginning of Section 2.3, Patient Centered Data Entry.

2.3.6 Last MH/SS Visit

- To view information related to a patient's case, type "6" at the "Select Action:" prompt in the View Patient Record Screen and press <RETURN>.

The MH/SS Visit Record Display Screen for the selected patient record will be displayed. This screen and its options are detailed in Section 2.1.5, Display Record.

2.3.7 Display Meds

- To view a patient's medication list, type "7" at the "Select Action:" prompt in the View Patient Record Screen and press <RETURN>.

The Medication List for the selected patient will be displayed.

```
OUTPUT BROWSER           May 27, 1997 11:45:52       Page: 1 of 1
Medication List for WILSON,JIMMY

*** Medications Prescribed entries in MHSS Database for last 2 years ***

The last of each type of medication from the PCC Database is displayed below.

      Enter ?? for more actions                >>>
+ NEXT SCREEN      - PREVIOUS SCREEN    Q QUIT
Select Action: +//
```

Medication List for a Specific Patient

- To advance to the second screen of the Medication List, type "+" at the "Select Action:" prompt and press <RETURN>.
- To go back to the first screen of the Medication List, type "-" at the "Select Action:" prompt and press <RETURN>.
- To return to the View Patient Record Screen, type "Q" (Quit) and press <RETURN>.

- To view more options, type “??” at the “Select Action:” prompt and press <RETURN>.

The following options (actions) will be displayed.

The following actions are also available:			
+	Next Screen	FS First Screen	SL Search List
-	Previous Screen	LS Last Screen	ADPL Auto Display(On/Off)
UP	Up a Line	GO Go to Page	QU Quit
DN	Down a Line	RD Re Display Screen	
>	Shift View to Right	PS Print Screen	
<	Shift View to Left	PL Print List	
Enter RETURN to continue or '^' to exit:			

- To use one of the above options, press <RETURN> at the “Enter RETURN to continue or “^” to exit:” prompt.
- Enter the option you want next to the “Select Action:” prompt and press <RETURN>.
- Enter the information requested at each prompt.

2.3.8 Appointments

- To view scheduling information, type “8” at the “Select Action:” prompt in the View Patient Record Screen and press <RETURN>.

The Scheduling Actions Available Menu will be displayed. The options in this menu are detailed below.

SCHEDULING ACTIONS AVAILABLE
1. MAKE APPOINTMENT
2. CANCEL APPOINTMENT
3. CHECK-IN/WALK-IN/CHART REQUEST
4. DISPLAY APPOINTMENT
Select Action by number: (1-4):

Scheduling Actions Available Menu

Make Appointment

- To schedule an appointment for a patient, type "1" at the "Select action by number: (1-4):" prompt in the Scheduling Actions Available Menu and press <RETURN>.

The "Select Clinic:" prompt will be displayed.

```
Select CLINIC: ABQ GENERAL CLINIC
Enter EARLIEST POSSIBLE APPT DATE: TODAY// (MAY 28, 1997)
Enter LATEST POSSIBLE APPT DATE: T+15//
```

- Type information at each prompt as requested and press <RETURN> to record your entry.

Cancel Appointment

- To cancel an appointment for a patient, type "2" at the "Select action by number: (1-4):" prompt in the Scheduling Actions Available Menu and press <RETURN>.

The "Do You Want To Cancel (P)ast Or (F)uture Appointments?" prompt will be displayed.

```
Cancel Appointment for WILSON,JIMMY

DO YOU WANT TO CANCEL (P)AST OR (F)UTURE APPOINTMENTS? F//
APPOINTMENTS CANCELLED BY (P)ATIENT OR BY (C)LINIC? P//
READY TO CANCEL PENDING APPTS
```

- Type information at each prompt as requested and press <RETURN> to record your entry.

Check-In/Walk-In/Chart Request

- To add an unscheduled appointment, check in a patient for an appointment, or request a chart to review for a patient, type “3” at the “Select action by number: (1-4):” prompt in the Scheduling Actions Available Menu and press <RETURN>.

The selected patient's scheduled appointments for the current date will be displayed. If a patient has no appointments scheduled, a “No Pending Appointments for Today” statement will be displayed.

```
***** TODAY'S APPOINTMENTS *****
1  MAY 28, 1997  14:17 (20 MINUTES) ALB MENTAL HEALTH UNSCHEDULED
2  MAY 28, 1997  14:24 (20 MINUTES) ABQ GENERAL CLINIC UNSCHEDULED

*** NOTE - PATIENT IS NOW IN 3SO WARD ***
1. ADD NEW UNSCHEDULED APPOINTMENT (WALK-IN)
2. CHECK-IN PATIENT FOR SCHEDULED APPOINTMENT
3. REQUEST CHART FOR REVIEW

Choose Action: (1-3):
```

- Type the number of the option you want to access next to the “Choose Action: (1-3):” prompt and press <RETURN>.
- Type information at each prompt as requested and press <RETURN> to record your entry.

Display Appointment

- To display a patient's appointment schedule, type “4” at the “Select action by number: (1-4):” prompt in the Scheduling Actions Available Menu and press <RETURN>.

The “Do you want to see only pending appointments?” prompt will be displayed.

```
Do you want to see only pending appointments? No// (No) <RETURN>

***** Date Range Selection *****

Beginning DATE : May 25, 1997 (MAY 25, 1997)

Ending DATE : May 28, 1997 (MAY 28, 1997)

DEVICE: HOME//  RIGHT MARGIN: 80//
```

- If you want to view appointments between a date range, type the beginning and ending dates at the prompts as displayed above.

NOTE: If you type "Y" (Yes) at the "Do you want to see only pending appointments?" prompt, you will not be prompted to enter a beginning and ending date range.

- Type a print device at the "Device:" prompt and press <RETURN>.

The appointment schedule for the patient you selected will print, as displayed below.

```
Confidential Patient Data Covered by Privacy Act
APPOINTMENTS FOR: WILSON,JIMMY  11-26-96  PRINTED: 05/28/97@1645
=====
MAY 28, 1997  2:17 PM (20 MINUTES)  ALB MENTAL HEALTH
MAY 28, 1997  2:24 PM (20 MINUTES)  ABQ GENERAL CLINIC
      None
Press RETURN to continue:
```

2.3.9 Quit

- To exit the View Patient Record Screen, type "Q" (Quit) at the "Select Action:" prompt and press <RETURN>.

The "Select Patient Name:" prompt will be displayed.

- Type the patient name you want to display at the "Select Patient Name:" prompt and press <RETURN>.

OR

- Press <RETURN> at the "Select Patient Name:" prompt to display the MH/SS Main Screen.

2.4 Group Form Data Entry

Use this option to enter encounter data when the encounter involves a group of patients. The Group Form Data Entry option is a roll and scroll format that allows you to enter data into each participant's record without entering an encounter record for each patient.

NOTE: Only the direct contact data can be added to the patient's visit file. Manipulation of problem lists, treatment notes, and other forms of record tagging have to be done using individual service encounter records.

- **To enter encounter data for a group of patients, type "GRP" at the prompt in the Data Entry Menu and press <RETURN>.**

The "Enter Encounter Date:" prompt will be displayed.

- Type the encounter date on which you want to enter the group of patients and press <RETURN>.
- Type information as requested at the prompts and press <RETURN> to record your entries, as displayed below.

The data entered during the group data entry process is the same data entered for individual encounter records. For descriptions of each data field and instructions on what to enter, refer to Section 2.1.1, Add Patient Visit.

NOTE: After you enter the requested information and the patients' names at the bottom of the screen, the data you enter in the Group Data Entry Screen will be recorded and listed in the Update MH/SS Forms Screen on the date you typed next to the "Enter Encounter Date:" prompt.

This is the GROUP Data Entry Option: You will be asked to enter the total number of visits, the total Activity Time for ALL Patients listed on the Group Form, and all other pertinent information required for a visit.
.....You MUST complete ALL entries prior to leaving this option.....

Enter ENCOUNTER DATE: T (FEB 21, 1997) (FEB 21, 1997)
Enter PROGRAM: (M/S/O): MENTAL HEALTH
Enter CLINIC (not required): MENTAL HEALTH 14
ARRIVAL Time: 12:00// 1:30 (FEB 21, 1997@13:30)
Select LOCATION NAME: SELLS HOSPITAL/CLINIC// <RETURN> 001 TUCSON SELLS
Enter PRIMARY PROVIDER: ADAM,ADAM ADAM
Enter SECONDARY PROVIDER: SMITH,MARY
Enter SECONDARY PROVIDER: <RETURN>
Enter COMMUNITY: LITTLE TUCSON PIMA ARIZONA 009 0410009
Enter ACTIVITY: 14 FAMILY/GROUP TREATMENT-PATIENT PRESENT FAM
Enter TYPE OF CONTACT: 2 OUTPATIENT CLINIC 2
Enter PROBLEM (POV): 53 ADULT/CHILD RELATIONSHIP
Provider Narrative: PARENTING SKILLS GROUP
Enter PROBLEM (POV): <RETURN>
Enter TOTAL ACTIVITY TIME: 60

Enter TOTAL NUMBER OF PATIENTS ON FORM: 2
I am going to ask you to enter 2 patient names. I will then create a record in the MHSS file for each patient.
The record will contain the following information:

Date of Encounter: FEB 21, 1997@13:30 Program: Mental Health
Loc. of Enc.: SELLS HOSPITAL/CLINIC Community: LITTLE TUCSON
Providers: ADAM,ADAM
Activity: FAMILY/GROUP TREATMENT-PA Type of Contact: OUTPATIENT CLINIC
PROBLEM (POV): 53 PARENTING GROUP
Patients: 2 Total Time: 60
Do you wish to continue? Y// <RETURN> YES

Select PATIENT NAME: WILSON,JIMMY M 01-01-71 000170001 SE 123456

Creating new record for WILSON,JIMMY.

SUBJECTIVE/OBJECTIVE: <RETURN>
1> <RETURN>
EDIT Option: <RETURN>
COMMENT: GOOD PARTICIPATION

Generating PCC Visit.

Select PATIENT NAME: FLINTSTONE,ABNER M 09-08-69 SE 768987

Creating new record for FLINTSTONE,ABNER.

SUBJECTIVE/OBJECTIVE: <RETURN>
1> <RETURN>
COMMENT: SEEMED PREOCCUPIED

Generating PCC Visit.

Do you wish to PRINT an encounter form for each patient's chart? N// NO

Group Data Entry Screen

2.5 Activity Record Log Data Entry

Use the Activity Record Log Data Entry option to record provider's activities that do not involve patient contact (e.g., administrative responsibilities, community services, and travel).

- **To record provider activities (other than patient contact), type "ACT" at the prompt in the Data Entry Menu and press <RETURN>.**

The "Enter Primary Provider:" prompt will be displayed.

- Type the name of the primary provider whose activities you want to enter and press <RETURN>.
- Type information as requested at the prompts and press <RETURN> to record your entries, as displayed below.

NOTE: For descriptions of each data field and instructions on what to enter, refer to Section 2.1.1, Add Patient Visit, and Section 2.1.2, Add Non-Patient Record.

After you enter all the required information, a new record will be created.

```
*** ACTIVITY RECORD LOG Data Entry Option ***

You will be prompted to enter all pertinent Record information
You will NOT be prompted to enter the Patient Names
.....Only the following ACTIVITY CODES are acceptable Entries.....

**32-43**51-59**63-65*72**83-84**

Enter PRIMARY PROVIDER: ADAM,ADAM      ADAM
Enter PROGRAM: (M/S/O): SOCIAL SERVICES
Select LOCATION NAME: SAN XAVIER HEALTH CENTER      TUCSON  SELLS 11
Enter ENCOUNTER DATE: T (FEB 21, 1997) (FEB 21, 1997)
Enter COMMUNITY: TUCSON      PIMA  ARIZONA  077  0410077
Enter ACTIVITY: 41      EDUCATION/TRAINING PROVIDED
Enter TOTAL NUMBER SERVED: 1
Enter TOTAL ACTIVITY TIME: 90
Enter TYPE OF CONTACT: 1 ADMINISTRATIVE      1
Enter PROBLEM (POV): 96      TRAINING NEEDS
Provider Narrative: ORIENTATION FOR NEW THERAPIST

Creating new record
***COMPLETED SUCCESSFUL ENTRY OF RECORD***
```

Activity Record Log

2.6 Update Patient Data

Use this option to update (add, modify, or delete) patient data not recorded in the individual encounter records.

- **To update or append information on a patient encounter, type “UPT” at the prompt in the Data Entry Menu and press <RETURN>.**

The “Select Patient Name:” prompt will be displayed.

- Type the name of the patient whose record you want to update or append at the “Select Patient Name:” prompt and press <RETURN>.
- Type the location where the encounter you want to update or append took place next to the “Select Location Name:” prompt and press <RETURN>.
- Type the date that you updated or appended the patient encounter information next to the “Enter Date Noted:” prompt and press <RETURN>.
- Type the name of the provider updating or appending the patient encounter record next to the “Enter Provider:” prompt and press <RETURN>.

The Other Information Screen will be displayed. This screen lists the types of patient data you may update, add, or edit.

NOTE: This option is similar to Section 2.1.4, Update Patient Information. For descriptions of each data field and instructions on what to enter, refer to Section 2.1.4, Update Patient Information.

***** OTHER INFORMATION *****
Update, add or append any of the following data
1).Update any of the following information: Designated Providers, Patient Flag
2). Patient Case Open/Admit/Closed Data
3). MHSS Patient Diagnosis List
4). Enter Local Service Site
5). Personal History Information
6). Print an Encounter Form
7). None of the Above (Quit)
Choose one of the above: (1-7): 7//4 <RETURN>
LOCAL SERVICE SITE:

Other Information Screen

2.7 Display Patient's Last MH/SS Visit

Use this option to quickly review the information entered for a particular patient's last Mental Health/Social Services visit.

- **To view information entered for a patient's last visit, type "PLV" at the prompt in the Data Entry Menu and press <RETURN>.**

The "Enter Patient:" prompt will be displayed.

- Type the name, date of birth, or health record number of the patient whose previous visit you want to view at the "Enter Patient:" prompt and press <RETURN>.

The following viewing options will be displayed.

Select one of the following:	
E	Encounter Form Format
S	Standard Display
Select Print Format: E//	

- Type the corresponding letter of the option you want to view next to the "Select Print Format:" prompt and press <RETURN>.

Encounter Form Format

If you select the Encounter Form Format, refer to Section 2.1.7, Print Encounter Record, for descriptions of each data field and instructions on what to enter.

Standard Display

If you select Standard Display, refer to Section 2.1.5, Display Record, for descriptions of each data field and instructions on what to enter.

2.8 Print Encounter Record

Use this option to print an encounter record from within the screen data entry process. You have the option to specify a particular patient or a particular provider, or you may print a record for all patients and all providers between specified dates.

- To print a patient encounter record, type “PRT” at the prompt in the Data Entry Menu and press <RETURN>.

The Encounter Form Print Screen will be displayed.

```
***** ENCOUNTER FORM PRINT *****  
  
This report will produce hard copy computer generated encounter forms.  
  
Please enter the date range for which forms should be printed.  
  
Enter beginning Date: May 28, 1997 (MAY 28, 1997)  
  
Enter ending Date: (5/28/97 - 5/30/97): MAY 28, 1997// (MAY 28, 1997)  
Do you wish to print forms for one particular PATIENT? Y// ES  
  
Enter PATIENT Name: WILSON,JIMMY M 01-02-50 333882211 AH 59294  
Do you wish to print forms for one particular PROVIDER? Y// ES  
Enter PROVIDER Name: ADAM, ADAM ADAM,ADAM
```

Encounter Form Print Screen

- Type the date you want to begin printing encounter records next to the “Enter beginning Date:” prompt, and press <RETURN>.
- Type the date you want to stop printing encounter records next to the “Enter ending Date:” prompt and press <RETURN>.

NOTE: If you want to print records for only one particular day, press <RETURN> at the “Enter ending Date:” prompt (the encounter records printed will be only for the date entered at the “Enter beginning Date:” prompt).

- Type “Y” (Yes) or “N” (No) next to the “Do you wish to print forms for one particular Patient?” prompt and press <RETURN>.

- Type “Y” (Yes) or “N” (No) next to the “Do you wish to print forms for one particular Provider?” prompt and press <RETURN>.

The following screen will be displayed. You may print a Full Encounter Form, a Suppressed Encounter Form, or both. Refer to Section 2.1.7, Print Encounter Record, for descriptions of each data field and instructions on what to enter.

Select one of the following:	
F	Full Encounter Form
S	Suppress Subjective/Objective/Chief Complaint Encounter Form
B	Both
What type of form do you want to print: B//	
DEVICE: HOME//	

- Type a print device at the “Device:” prompt and press <RETURN>.

The encounter record(s) you selected will print (see Section 2.1.7, Print Encounter Record, for examples of a Full Encounter Form and a Suppressed Encounter Form).

2.9 Update MH/SS Patient Treatment Plans

Use this option to update, display, or print treatment plans in a patient's MH/SS record. Data from the treatment plans are not passed to the PCC and the plan is not systematically linked to data in the MH/SS file, other than the patient identification information. It is a stand-alone component of patient care.

Very few fields are required in the treatment plan (identified provider and date). Some fields have constraints in terms of the data that can be entered (e.g., the Diagnosis field is limited to the MH/SS problem codes).

- **To update an MH/SS Patient Treatment Plan, type "TPU" at the prompt in the Data Entry Menu and press <RETURN>.**

The Patient Treatment Plans Menu will be displayed. The options in this menu are detailed in the following subsections.

```
*****  
**      IHS Mental Health/Social Services System      **  
**                      Patient Treatment Plans        **  
*****  
                          Version 2.0  
  
                        ALBUQUERQUE HOSPITAL  
  
UP   Update (add,edit,delete) a Treatment Plan  
DTP  Display/Print a Treatment Plan  
RES  Print List of Treatment Plans needing Resolved  
  
Select Update MHSS Patient Treatment Plans Option:
```

Patient Treatment Plans Menu

2.9.1 Update (add, edit, delete) a Treatment Plan

- To edit, delete, view, or print a Treatment Plan, type “UP” at the prompt in the Patient Treatment Plans Menu and press <RETURN>.

The “Select Patient Name:” prompt will be displayed.

```
Mental Health/Social Services Module
*****
* Update MH/SS Patient Treatment Plans *
*****
Select PATIENT NAME: WILSON,JIMMY    M 08-15-95    AH 112696
```

Mental Health/Social Services Module Screen

- Type the name of the patient whose Treatment Plan you want to review next to the “Select Patient Name:” prompt and press <RETURN>.

The Update Patient Treatment Plan Screen will be displayed. You have several options at the bottom of this screen (e.g., you may add, edit, or delete a Treatment Plan). You may also use this screen to enter a Treatment Plan Review or update a Treatment Plan Goal. These and all available options are detailed in the following subsections.

```
Update Patient Treatment Plan Jun 13, 1997 15:53:13    Page: 1 of 1
Patient Name: WILSON,JIMMY    DOB: AUG 15, 1995    Sex: M
TREATMENT PLANS CURRENTLY ON FILE

1) Date Established: MAY 22, 1997    Responsible Provider: <<not recorded>>
   Problem: <<not recorded>>
   Date Resolved:

2) Date Established: MAY 27, 1997    Responsible Provider: BELL,CURTIS
   Problem: 333.90 - MEDICATION-INDUCED MOVEMENT DISORDER NOS
   Problem: 28 - DRUG DEPENDENCE
   Problem: 290.40 - VASCULAR DEMENTIA, UNCOMPLICATED
   Date Resolved:

3) Date Established: MAY 28, 1997    Responsible Provider: <<not recorded>>
   Problem: <<not recorded>>
   Date Resolved:

Enter ?? for more actions
AD Add Treatment Plan    RV Enter TP Review    HS Health Summary
ED Edit a Plan          UG Update a TP Goal    SL Search List
DE Delete Tx Plan      DS Disp/Print Plan    Q Quit
Select Action: AD//
```

Update Treatment Plan Screen

2.9.1.1 Add Treatment Plan

- To add a treatment plan to a patient's record, type "AD" at the prompt in the Update Patient Treatment Plan Screen and press <RETURN>.

The following screen will be displayed.

```
-----  
Patient Name: WIILSON ,JIMMY  DOB: JAN 02, 1950  Sex: MALE  
-----  
Creating new Treatment Plan...  
  
*****Treatment Plan Update for WILSON,JIMMY *****  
  
The following 6 questions relate to the Patient's Problem, please enter all available  
data.  
  
Problem/Diagnosis Code...: 15      BIPOLAR DISORDER  
Additional Problem/Diagnosis Code...: 16      DELUSIONAL DISORDER  
Additional Problem/Diagnosis Code...: <RETURN>  
Problem Description (Describe all Problems).....:  
  1>Two types of disorders.  
EDIT Option: <RETURN>  
  
AXIS I.....: 33  
AXIS II.....: 22  
AXIS III.....: 55  
AXIS IV.....: 66  
AXIS V.....: 23  
Responsible Therapist....: Adam,Adam  
  
Discharge Criteria.....:  
  1>Must solve problems.  
EDIT Option: <RETURN>  
  
Notes/Comments.....:  
  1>None  
EDIT Option: <RETURN>  
  
Revise/Resolve by Date...: JULY 18, 1997 (JUL 18, 1997)  
Next Review Date.....: JULY 3, 1997 (JUL 03, 1997)  
Concurring Supervisor....: Doctor,A  
Date Supervisor Concurred: T (JUN 16, 1997)  
  
Concurring Physician.....: Adam,First ADAMS,FIRST  
Date Physician Concurred.: T (JUN 16, 1997)  
Date Closed/Resolved.....: <RETURN>
```

- Type information as requested at each prompt and press <RETURN> to record your entries, as displayed above.

Add a Treatment Goal

- After you enter the information in the above screen, the Update Goals For This Treatment Plan Screen will be displayed. In this screen, you have the option to add a new goal or edit an existing goal for a Treatment Plan.

```
**** UPDATE GOALS FOR THIS TREATMENT PLAN ****

You may edit one of the existing GOAL'S or add a new one

No Treatment Goals currently recorded.

Do you wish to ADD a Treatment Goal? Y// <RETURN>

Adding a NEW GOAL...

Responsible Therapist.....: Adam,Adam
Date Goal Established.....: T (JUN 16, 1997)
Goal.....:
  1>To solve disorder problems by end of July 1997.
  2>
EDIT Option:
Method.....: Weekly meetings with therapist.
Duration.....: Four weeks.
Target Date.....: July 31, 1997 (JUL 31, 1997)
Status.....: ??
  Choose from:
  A   ATTAINED
  C   CONTINUED
  R   REVISED
Status.....: c CONTINUED
Date Reviewed with Client.: T (JUN 16, 1997)
```

- If you do **not** want to add a new Treatment Goal, type “N” (No) at the “Do you wish to Add a Treatment Goal?” prompt and press <RETURN> to display the Update Patient Treatment Plan Screen.

OR

- To add a new Treatment Goal, type “Y” (Yes) at the “Do you wish to Add a Treatment Goal?” prompt and press <RETURN>.

- Type information as requested at each prompt and press <RETURN> to record your entries, as displayed above.

After a Treatment Goal is entered, the Update Goals For this Treatment Plan Screen will be displayed differently. The Treatment Goal(s) will be listed and your options will be listed, as displayed below.

**** UPDATE GOALS FOR THIS TREATMENT PLAN ****

You may edit one of the existing GOAL'S or add a new one

Goals currently on file:

1) Date Goal Established: JUN 16, 1997 Therapist: ADAM,ADAM
To solve disorder problems by end of July 1997.

Select one of the following:

E EDIT one of the above GOAL's
A ADD a new GOAL
D DELETE one of the above GOAL's
Q QUIT

Do you wish to:

2.9.1.2 Edit a Plan

- To edit a Treatment Plan, type "ED" at the "Select Action:" prompt in the Update Patient Treatment Plan Screen and press <RETURN>.

The "Select MHSS Treatment Plan:" prompt will be displayed.

- Type the number of the Treatment Plan you want to edit next to the "Select MH/SS Treatment Plan:" prompt and press <RETURN>.

The Treatment Plan Update Screen for the patient record you selected will be displayed.

- Type your edits after each prompt and press <RETURN> to record your changes.

2.9.1.3 Delete Tx Plan

- To delete a Treatment Plan, type “DE” at the “Select Action:” prompt in the Update Patient Treatment Plan Screen and press <RETURN>.

The “Select MH/SS Treatment Plan:” prompt will be displayed.

- Type the number of the Treatment Plan you want to delete next to the “Select MH/SS Treatment Plan:” prompt and press <RETURN>.
- Type “Y” (Yes) at the “Are you sure you want to Delete this Treatment Plan?” prompt and press <RETURN>.

The Treatment Plan and the goals entered under the Treatment Plan you selected will be deleted, as displayed below.

Deleting all treatment goals.. Deleting Treatment Plan.. Treatment Plan for WILSON,JIMMY DELETED. Press return to continue....:
--

2.9.1.4 Enter TP Review

- To update the patient's Treatment Plan records after you review a Treatment Plan with the patient, type "RV" at the "Select Action:" prompt and press <RETURN>.

The "Select MH/SS Treatment Plan:" prompt will be displayed.

- Type the number of the Treatment Plan to which you want add a review date at the "Select MH/SS Treatment Plan:" prompt and press <RETURN>.

The Treatment Plan Update Screen for the patient you selected will be displayed.

```
*****Treatment Plan Update for WILSON,JIMMY*****  
  
Treatment Plan REVIEW Update  
  
Select REVIEW DATES: July 1, 1997  JUL 01, 1997  
Are you adding 'JUL 01, 1997' as a new REVIEW DATES (the 1ST for this MHSS  
PATIENT TREATMENT PLANS)? Y (Yes)  
Reviewing Therapist.....: Adam,First ADAMS,FIRST  
Reviewing Physician.....: Adam,Adam  
  
Outcomes:  
1>Meeting was successful.  
EDIT Option:  
  
Select PARTICIPANTS IN REVIEW:  
Next Review Date.....: July 15, 1997
```

Treatment Plan Update Screen

- Type the requested review information at the prompts and press <RETURN> to record your changes.

This portion of the Treatment Plan will be added to the Treatment Plan as the review section.

2.9.1.5 Update a TP Goal

- To update a patient's Treatment Plan Goal, type "UG" at the "Select Action:" prompt and press <RETURN>.

The "Select MHSS Treatment Plan:" prompt will be displayed.

- Type the number of the Treatment Plan you want to update at the "Select MH/SS Treatment Plan:" prompt and press <RETURN>.

The Update Goals For This Treatment Plan Screen will be displayed. You may edit, add, or delete a Treatment Plan goal. The edit, add, and delete options in the screen below are the same as those detailed in Add a Treatment Goal in Section 2.9.1.1, Add Treatment Plan.

```
**** UPDATE GOALS FOR THIS TREATMENT PLAN ****  
  
You may edit one of the existing GOAL'S or add a new one  
  
Goals currently on file:  
  
1) Date Goal Established: FEB 26, 1997  Therapist: ADAM,ADAM  
   LACK OF VERBAL FIGHTS WITH SIGNIFICANT OTHER FOR ONE WEEK  
  
Select one of the following:  
  
E   EDIT one of the above GOAL's  
A   ADD a new GOAL  
D   DELETE one of the above GOAL's  
Q   QUIT  
  
Do you wish to: E
```

Update Goals for This Treatment Plan Screen

2.9.1.6 Display/Print Plan

- To display or print a patient's Treatment Plan, type "DS" at the "Select Action:" prompt and press <RETURN>.

The "Select MH/SS Treatment Plan:" prompt will be displayed.

- Type the number of the Treatment Plan you want to display or print at the "Select MH/SS Treatment Plan:" prompt and press <RETURN>.

The following screen will be displayed.

Select one of the following:

P PRINT Output on Paper
B BROWSE Output on Screen

Do you wish to: P// P PRINT Output on Paper
DEVICE: HOME// <RETURN>

- Type the corresponding letter of the output you want to display or print next to the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Treatment Plan you selected will be displayed. Keep pressing <RETURN> to advance to the next screen.

```
***** CONFIDENTIAL PATIENT INFORMATION *****
*****
* TREATMENT PLAN      Name: WILSON,JIMMY      Page 1
* ALBUQUERQUE HOSPITAL  DOB: 1/20/31  Sex: M  Chart #: AH12031 *
*****

Date Established:      Jun 16, 1997
Revise/Resolve By:    Aug 01, 1997
Date Closed/Completed:
Therapist:           ADAM,ADAM
Supervisor:          DOCTOR,A      Date Concurred: 6/16/97
Physician:           DOCTOR,B      Date Concurred:
Diagnosis: 44.1 - ADULT ABUSE (SUSPECTED),PHYSICAL
Problem Description (NARRATIVE):
  None.
AXIS I:
AXIS II:
AXIS III:
AXIS IV:
AXIS V:
Discharge Criteria:
  None.
Notes/Comments:
  None.

=====
GOALS:
  No Goals currently recorded for this Treatment Plan.

-----
                        Client's Signature
-----

Therapist's Signature      Physician's Signature

Date of Review:          Jul 01, 1997
Reviewing Therapist:    ADAMS,FIRST
Reviewing Physician:    ADAM,ADAM
Next Review Date:       July 15, 1997
Outcomes:
  Meeting was successful.
Participants in Review:
PARTICIPANT NAME      RELATIONSHIP TO CLIENT

End of report. PRESS RETURN
```

Patient Treatment Plan

2.9.1.7 Health Summary

- To display or print a health summary, type "HS" at the "Select Action:" prompt and press <RETURN>.

The PCC Health Summary for the patient you selected will be displayed (see Section 2.1.8, Health Summary).

2.9.1.8 Search List

- To search for a word, date, or block of text, type "SL" at the "Select Action:" prompt and press <RETURN>.

The "Search for:" prompt will be displayed.

Select Action: AD// SL Search List Search for:

- Type the word, date, or block of text you want to find in the Update Patient Treatment Plan Screen at the "Search for:" prompt and press <RETURN>.

NOTE: Use this option if the patient's Treatment Plan List is extensive.

The word, date, or block of text you typed next to the "Search for:" prompt will be highlighted in the Update Patient Treatment Plan Screen. If you keep pressing <RETURN>, any other identifiers like the one you typed at the "Search for:" prompt will also be highlighted.

2.9.1.9 Quit

- To exit the Update Patient Treatment Plan Screen (or to enter a different patient's Treatment Plan), type "Q" at the "Select Action:" prompt and press <RETURN>.

The "Select Patient Name:" prompt will be displayed.

2.9.2 Display/Print a Treatment Plan

- To display or print a Treatment Plan without entering the Update a Treatment Plan process, type “DTP” at the prompt in the Patient Treatment Plans Menu and press <RETURN>.

NOTE: You must use the Update a Treatment Plan option to add, edit, delete, or update a patient's Treatment Plan.

The “Select Patient Name:” prompt will be displayed.

- Type the name of the patient whose Treatment Plan you want to display/print next to the “Select Patient Name:” prompt and press <RETURN>.

A list of Treatment Plans currently on file for the selected patient will be displayed.

```
Display/Print Treatment Plan Jun 17, 1997 16:04:10      Page: 1 of
Patient Name: WILSON,JIMMY  DOB: AUG 15, 1995  Sex: M
                TREATMENT PLANS CURRENTLY ON FILE

1) Date Established: MAY 22, 1997   Responsible Provider: ARDES,BOB
   Problem: <<not recorded>>
   Date Resolved:
2) Date Established: MAY 28, 1997   Responsible Provider: <<not recorded>>
   Problem: <<not recorded>>
   Date Resolved:
3) Date Established: JUN 13, 1997   Responsible Provider: <<not recorded>>
   Problem: 44.2 - ADULT ABUSE (SUSPECTED),EMOTIONAL
   Date Resolved:
4) Date Established: JUN 13, 1997   Responsible Provider: ADAM,ADAM
   Problem: 2 - CROSS-CULTURAL ISSUE
   Issues More issues
   Date Resolved:
5) Date Established: JUN 13, 1997   Responsible Provider: <<not recorded>>
+   Enter ?? for more actions
DS  Disp/Print Plan      PS  Previous Screen  PL  Print List
HS  Health Summary      DN  Down a Line     SL  Search List
NS  Next Screen         UP  Up a Line       Q   Quit
Select Action:DS//
```

List of Treatment Plans on File Screen

2.9.2.1 Display/Print Plan

See Section 2.9.1.6, Display/Print Plan, for details on this option.

2.9.2.2 Health Summary

See Section 2.9.1.7, Health Summary, for details on this option.

2.9.2.3 Next Screen

- To advance to the next screen of a Display/Print Treatment Plan Screen, type “NS” at the “Select Action:” prompt and press <RETURN>.

The screen will be advanced by one page. Keep typing “NS” until the Treatment Plan you want to display or print is displayed on screen.

2.9.2.4 Previous Screen

- To back up to the previous screen of a Display/Print Treatment Plan Screen, type “PS” at the “Select Action:” prompt and press <RETURN>.

The screen will be backed up by one page. Keep typing “PS” until the Treatment Plan you want to display or print is displayed on screen.

2.9.2.5 Down a Line

- To move down one line in a Display/Print Treatment Plan Screen, type “DN” at the “Select Action:” prompt and press <RETURN>.

The screen will be moved down by one line. Keep typing “DN” until the line you want to display or print is displayed on screen.

2.9.2.6 Up a Line

- To move up one line in a Display/Print Treatment Plan Screen, type “UP” at the “Select Action:” prompt and press <RETURN>.

The screen will be moved up by one line. Keep typing “UP” until the line you want to display or print is displayed on screen.

2.9.2.7 Print List

- To display/print a patient’s entire list of Treatment Plans, type “PL” at the “Select Action:” prompt and press <RETURN>.

The patient’s list of Treatment Plans will be displayed. Keep pressing <RETURN> to advance to the next screen.

2.9.2.8 Search List

See Section 2.9.1.8, Search List, for details on this option.

2.9.2.9 Quit

- To exit the Display/Print Treatment Plan Screen (or to enter a different patient's Treatment Plan), type "Q" at the "Select Action:" prompt and press <RETURN>.

The "Select Patient Name:" prompt will be displayed.

2.9.3 Print List of Treatment Plans Needing Resolved

- To print a list of patients whose Treatment Plans need to be revised or resolved within a time frame defined by the provider, type "RES" at the prompt in the Patient Treatment Plans Menu and press <RETURN>.

The List Treatment Plans by Revise/Resolve Date Screen will be displayed.

NOTE: This report is generated based upon the Revise/Resolve date entered in the Treatment Plan.

***** LIST TREATMENT PLANS BY REVISE/RESOLVE DATE *****
This report will list all patients who have treatment plan which is due to be revised or resolved in a date range specified by the user.
Please enter the date range during which the treatment plan is to be revised or resolved.
Enter BEGINNING Date: April 24, 1997 (APR 24, 1997) <RETURN>
Enter ENDING Date: (6/17/97 - 99/99/99): JUN 17, 1997// (JUN 17, 1997)

List Treatment Plans by Revise/Resolve Date Screen

- Type the date you want to start printing the Treatment Plans that need to be revised/resolved at the "Enter Beginning Date:" prompt and press <RETURN>.

- Type the date you want to stop printing the Treatment Plans that need to be revised/resolved at the "Enter Ending Date:" prompt and press <RETURN>.

The following screen will be displayed. In this screen, you may select whether you want to print the Treatment Plans for all therapists or for an individual therapist.

```
You can limit the report output to treatment plans for one or all Therapists

Select one of the following:
  O   One Therapist
  A   All Therapists

List treatment plans for: O// <RETURN>

Which Responsible Therapist: Adam,Adam
DEVICE: HOME// <RETURN>
```

- Type the corresponding letter of the option you want next to the "List treatment plans for:" prompt and press <RETURN>.
- If you want to list Treatment Plans for an individual therapist, type the name of the therapist next to the "Which Responsible Therapist:" prompt and press <RETURN>.
- Type a print device at the "Device:" prompt and press <RETURN>.

A Listing of Treatment Plans Due to Be Revised/Resolved Screen will be displayed.

```
***** CONFIDENTIAL PATIENT INFORMATION ***** Page 1
                ALBUQUERQUE HOSPITAL
LISTING OF TREATMENT PLANS DUE TO BE REVISED/RESOLVED
                Date Range: JUN 17, 1997 to JUN 17, 1997

PATIENT NAME      DOB      CHART #   REVISE   THERAPIST
                  DATE

-----
NO DATA TO REPORT

RUN TIME (H.M.S): 0.0.0
End of report. PRESS RETURN:
```

Listing of Treatment Plans Due to Be Revised/Resolved

2.10 Generate Health Summary

Use this option to print a health summary for an individual patient. You may select the type of health summary you want to print.

- **To print (generate) a health summary, type “GHS” at the prompt in the Data Entry Menu and press <RETURN>.**

The “Select health summary type:” prompt will be displayed.

```
Select health summary type: DIABETES STANDARD//  
  
Select patient: WILSON,JIMMY      M 01-02-50 333882211  AH 59294  
Patient's chart number is 59294  
  
DEVICE: HOME// <RETURN>
```

- Enter the type of health summary you want to view next to the “Select health summary type:” prompt and press <RETURN>.

NOTE: To view a list of available health summary types, type “??” next to the “Select Health Summary Type Name:” prompt and press <RETURN>.

```
Choose from:  
ADULT REGULAR  
DENTAL  
DIABETES STANDARD  
IMMUNIZATION  
MENTAL HEALTH/SOCIAL SERVICES  
PATIENT MERGE (COMPLETE)  
PEDIATRIC  
PROBLEM LIST  
SAMPLE
```

- Type the patient’s name, date of birth, or social security number next to the “Select patient:” prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Confidential Patient Information Screen (with health summary information on the selected patient) will print, as displayed below. Keep pressing <RETURN> to advance to the next screen.

NOTE: The Demographic Data category in the Confidential Patient Information Screen is always the same. The other categories vary, depending on the type of health summary you select. If no information is entered under the health summary type you selected, Demographic Data will be the only category displayed when you print.

```
***** CONFIDENTIAL PATIENT INFORMATION -- JUN 10,1997 2:18 PM *****
***** WILSON,JIMMY (DIABETES STANDARD SUMMARY) pg. 1 *****

----- DEMOGRAPHIC DATA -----
WIDEFOOT,JIMMY          DOB: JAN 2,1950  MALE  <no blood type>
ALABAMA AND COUSHATTA TRIBES OF  MOTHER: WILSON,MARY
(H) 505-5551111          SSN: 333-88-2211
TESUQUE (123 ADOBE ROAD,SANTA FE,NM,87054)
LAST UPDATED: MAR 13,1997      ELIGIBILITY: CHS & DIRECT

HEALTH RECORD NUMBERS: 059294 ALBUQUERQUE HOSPITAL
PRINCIPAL PROVIDER: DOCTOR,A

----- ACTIVE PROBLEMS -----
ENT. MODIFIED
AH1    04/97 04/24/97 Patient is working on problem. (onset 05/01/96)

----- SCHEDULED ENCOUNTERS (max 5 visits or 30 days) -----

----- INPATIENT STAYS (max 5 visits or 5 years) -----
02/18/97-02/21/97 ALBUQUERQ HO  <no visit data>

----- OUTPATIENT/FIELD VISITS (max 10 visits or 2 years) -----

----- HEALTH MAINTENANCE REMINDERS -----
      LAST          NEXT
BLOOD PRESSURE     DUE NOW
WEIGHT             DUE NOW
RECTAL            DUE NOW
TONOMETRY         DUE NOW
BLOOD GLUCOSE     DUE NOW

*** END ** CONFIDENTIAL PATIENT INFORMATION -- JUN 10,1997 2:18 PM ***
```

Confidential Patient Information (Health Summary) Screen

2.11 Display Record Options

Use this option to display/list various records/visits.

- To display record options, type “DSP” at the prompt in the Data Entry Menu and press <RETURN>.

The following menu will be displayed. Each of the options in the menu below is detailed in the sections below.

```
RDSP  Display MH/SS Record
VDSP  Display a PCC Visit
LIST  List MH/SS Records, STANDARD Output
FC    Count Forms Processed By Data Entry

Select Display Record Options Option:
```

Display Record Options Menu

Display MH/SS Record

- To view the MH/SS Visit Record Display for a patient, type “RDSP” at the “Select Display Record Options Option:” prompt in the Display Record Options Menu above and press <RETURN>.

The “Enter Encounter Date:” prompt will be displayed.

```
Enter ENCOUNTER DATE: April 24, 1997 (APR 24, 1997) (APR 24, 1997)
Enter LOCATION OF ENCOUNTER (if known, otherwise press return):

Enter PATIENT (if known, otherwise press return): WILSON,JIMMY
                                           M 08-15-95      AH 112696
```

- Type the date the encounter you want to view took place at the “Enter Encounter Date:” prompt and press <RETURN>.
- Type the location of the encounter (if known) next to the “Enter Location of Encounter:” prompt and press <RETURN>. (This response is optional.)

- Type the patient's name, date of birth, or social security number next to the "Enter Patient:" prompt and press <RETURN>.

OR

- If you do not know the name of the patient, press <RETURN> at the "Enter Patient:" prompt.

A list of all encounters that took place on the date you entered next to the "Enter Encounter Date:" prompt will be displayed. The patient name is not listed here.

- Type the number of the record you want to display next to the "Which record do you want to display:" prompt and press <RETURN>.

The MH/SS Visit Record Display Screen will be displayed (see Section 2.1.5, Display Record, to view an example of the MHSS Visit Record Display Screen).

Display a PCC Visit

- To view a PCC Visit for a patient, type "VDSP" at the "Select Display Record Options Option:" prompt in the Display Record Options Menu above and press <RETURN>.

The "Select Patient Name:" prompt will be displayed.

Select PATIENT NAME: WILSON,JIMMY	M 08-15-95	AH 112696
Enter VISIT date:		

- Type the patient's name, date of birth, or social security number next to the "Select Patient Name:" prompt and press <RETURN>.
- Type the date the PCC visit you want to view took place next to the "Enter Visit Date:" prompt and press <RETURN>.

List MH/SS Records, STANDARD Output

- To view a detailed or brief listing of MH/SS contacts, type “LIST” at the “Select Display Record Options Option:” prompt in the Display Record Options Menu above and press <RETURN>.

The Mental Health/Social Services Record List Screen will be displayed. A description of this option is displayed at the top of this screen (see below).

```
***** Mental Health/Social Services Record List *****
This report will produce either a detailed, or brief listing of Mental Health and Social
Services contacts. The list of contacts will be for a date range specified by the user and
contacts can be selected based on any of the following items: Provider, Program,
Provider Discipline, Problem Code, Activity Type, Type of Contact, Patient Age, Patient
Sex, Patient Tribe Patient Community, Community of Service, or Location of
Encounter. The user can select any number of these screens.

Enter beginning Contact Date for Search: April 24, 1997 (APR 24, 1997)

Enter ending Contact Date for Search: (4/24/97-6/12/97): APR 24, 1997// (APR 24,
1997)

Record selection criteria:
Encounter Date range: APR 24, 1997 to APR 24, 1997.
```

Mental Health/Social Services Record List Screen

- Type the date you want to begin listing MH/SS contacts next to the “Enter beginning Contact Date for Search:” prompt and press <RETURN>.

- Type the date you want to stop listing MH/SS contacts next to the "Enter ending Contact Date for Search:" prompt and press <RETURN>.

NOTE: If the ending date is the same as the beginning date, press <RETURN> after the "Enter ending Contact Date for Search:" prompt (as displayed above).

The Visit Selection Menu will be displayed. Type "+" at the "Select Action:" prompt on page 1 of this screen to view items on page 2. Use this screen to retrieve specific groups of data. The retrieval process is detailed in the subsections below.

MHSS GENERAL RETRIEVAL Jun 12, 1997 09:03:56 Page: 1 of 2

VISIT Selection Menu

Contacts can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected.

To bypass screens and select all contacts type Q.

1) Patient Name	21) Case Disposition	41) Axis V
2) Patient Sex	22) Next Case Review Dat	42) Flag (Local Use)
3) Patient Age	23) Appointment/Walk-In	43) Primary Provider
4) Patient DOB	24) Interpreter Utilized	44) Primary Prov Discipl
5) Patient DOD	25) Program	45) Primary Prov Affilia
6) Living Patients	26) Location of Encounte	46) Prim/Sec Providers
7) Chart Facility	27) Clinic	47) Prim/Sec Prov Discip
8) Patient Community	28) Outside Location	48) POV (Prim or Sec)
9) Patient County Resid	29) SU of Encounter	49) POV (Prob Code Grps)
10) Patient Tribe	30) County of Service	50) Primary POV
11) Eligibility Status	31) Community of Service	51) POV (ProblemCategor
12) Class/Beneficiary	32) Eval&Man CPT	52) POV Diagnosis Catego
13) Medicare Eligibility	33) Activity Type	53) Axis I/II Diagnoses
14) Medicaid Eligibility	34) Activity Category	54) Procedures (CPT)
15) Priv Ins Elibility	35) Number Served	55) Education Topics Pro
16) Patient Encounters O	36) Type of Contact	56) Personal History Ite
17) Patient Flag Field	37) Activity Time	57) Designated MH Prov
18) Case Open Date	38) Inpatient Dispositio	58) Designated SS Provid
19) Case Admit Date	39) PCC Visit Created	
20) Case Closed Date	40) Axis IV	

+ Enter ?? for more actions

S Select Item(s) + Next Screen Q Quit Item Selection

R Remove Item(s) - Previous Screen E Exit Report

Select Action: S// <RETURN>

Which record item(s): (1-58):

Visit Selection Menu

Select Item(s)

- To select a record item, press <RETURN> at the “Select Action:” prompt in the Visit Selection Menu, as displayed above.
- Type the number of the record item next to the “Which record item(s): (1-58):” and press <RETURN>.

The item (and item number) you selected will be displayed.

```
1) Patient Name Selection.  
ENTER Patient Name: WILSON,JIMMY M 01-02-50 333882211 AH 59294  
ENTER Patient Name: <RETURN>
```

- Type your entries next to the prompt and press <RETURN>.
- After you make all the entries you need for a particular record item, press <RETURN>, as displayed above.

The Visit Selection Menu will be redisplayed. If you want to enter more contact items, repeat the steps directly above.

Quit Item Selection

- After you select all the record items you want, type “Q” (Quit Item Selection) at the “Select Action:” prompt and press <RETURN>.

The Report Print Selection Screen will be displayed.

```
Report Print Selection.  
  
Select one of the following:  
D Detailed (132 column print)  
B Brief (80 column print)  
  
Type of Report to Print: D// <RETURN>
```

Report Print Selection Screen

- Type the corresponding letter of the report you want to print next to the "Type of Report to Print:" prompt and press <RETURN>.

The Sort Item Selection Menu will be displayed. Use this menu to select how you want to sort the record items entered. As stated in the Sort Item Selection Menu below, the records displayed can be sorted by only one item in the Sort Selection Menu.

SORT ITEM SELECTION MENU

The records displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by record date.

1) Patient Name	13) Appointment/Walk-In	25) Number Served
2) Patient Sex	14) Interpreter Utilized	26) Type of Contact
3) Patient DOB	15) Program	27) Inpatient Dispositio
4) Patient DOD	16) Location of Encounte	28) Axis V
5) Patient Chart #	17) Clinic	29) Flag (Local Use)
6) Patient Community	18) Outside Location	30) Primary Provider
7) Patient County Resid	19) SU of Encounter	31) Primary Prov Discipl
8) Patient Tribe	20) County of Service	32) Primary Prov Affilia
9) Eligibility Status	21) Community of Service	33) Primary POV
10) Class/Beneficiary	22) Eval&Man CPT	34) Designated MH Prov
11) Patient Flag Field	23) Activity Type	35) Designated SS Provid
12) Encounter Date	24) Activity Category	

Enter ?? for more actions

S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report

Select Action: S//

Select Action: S// Select Item(s)

Sort contacts by which of the above: (1-35): 1

Do you want a separate page for each Patient Name? N//

Sort Item Selection Menu

- To select the item by which you want to sort, press <RETURN> at the "Select Action:" prompt in the Sort Item Selection Menu, as displayed above.
- Type the number of the record item next to the "Which record item(s): (1-58):" and press <RETURN>.
- Type the number of the item by which you want to sort next to the "Sort contact by which of the above: (1-35):" prompt and press <RETURN>.

- Type "N" (No) or "Y" (Yes) at the "Do you want a separate page for each Patient Name?" prompt.

Do you want a separate page for each Patient Name? N// O

Select one of the following:

P PRINT Output

B BROWSE Output on Screen

Do you wish to : P//

DEVICE: HOME// <RETURN>

- Type the corresponding letter of the output you want displayed on your screen next to the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Mental Health/Social Services Record Listing Screen will be displayed. If the lines in this screen are too long, they will wrap to the next line, as shown below.

```

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING

REPORT REQUESTED BY: JONES,SUE

The following contact listing contains MH/SS contacts selected based on the following
criteria:

RECORD SELECTION CRITERIA

Encounter Date range: APR 24, 1997 to APR 24, 1997

Patient Name: WILSON,JIMMY ; WILSON,MARY

Report Type: STANDARD BRIEF OR DETAILED RECORD LIST

Press return to continue....:

ALBUQUERQUE HOSPITAL                                     Page 2

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING
Contact Dates: APR 24, 1997 and APR 24, 1997
=====
DATE/TIME PROVIDER PD PRG LOC COMMUNITY ACT AT CONT
HRN SEX AGE PROB NARRATIVE
=====
04/24/97@12:00 ADAM,ADAM 23 M AH WILSON,MARY25 3 OUTP AH
112696 F 1 45.2 ABUSIVE BEHAVIOR (ALLEGED), EM

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING
Contact Dates: APR 24, 1997 and APR 24, 1997
=====
DATE/TIME PROVIDER PD PRG LOC COMMUNITY ACT AT CONT HRN
SEX AGE PROB NARRATIVE
=====
04/24/97@12:00 ADAM,ADAM 23 M AH WILSON,JIM31 4 OUTP
AH 59294 M 47 38 None

Enter RETURN to continue or '^' to exit:
RUN TIME (H.M.S): 0.0.0
End of report. PRESS RETURN:
    
```

Mental Health/Social Services Record Listing

Remove Items

- To remove a record item already selected, type “R” at the “Select Action:” prompt in the Visit Selection Menu, as displayed above.
- Type the number of the record item you want to remove next to the “Remove which selected item:” prompt and press <RETURN>.

The item (number) you entered will be removed.

Exit Report

- To exit the Visit Selection Menu, type “E” at the “Select Action:” prompt and press <RETURN>.

Count Forms Processed By Data Entry

- To list a count of forms entered by data entry operators, type “FC” at the “Select Display Record Options Option:” prompt in the Display Record Options Menu above and press <RETURN>.

The following screen will be displayed. You may print a form count for one data entry operator or for all data entry operators between the date range you specify.

```
This report will generate a count of forms entered by a particular data entry
operator or for ALL data entry operators for a date range that you specify.

Enter beginning Posting Date: April 24, 1997 (APR 24, 1997)

Enter ending Posting Date: (4/24/97 - 6/13/97): APR 24, 1997// (APR 24, 1997)
Report on ALL Operators? Y// ES
DEVICE: HOME// <RETURN>
```

- Type the date you want to begin printing forms next to the “Enter beginning Posting Date:” prompt and press <RETURN>.
- Type the date you want to stop printing forms next to the “Enter ending Posting Date:” prompt and press <RETURN>.

NOTE: If the ending date is the same as the beginning date, press <RETURN> after the “Enter ending Posting Date for Search:” prompt (as displayed above).

- Type “Y” (Yes) or “N” (No) at the “Report on All Operators:” prompt to indicate if you want to print a report on all data entry operators or an individual data entry operator. If you type “N”, enter the requested information at the prompts.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Number of Forms Keyed Screen will print, as displayed below.

JUN 13,1997 Page 1			
ALBUQUERQUE HOSPITAL NUMBER OF FORMS KEYED			
DATE ENTRY OPERATOR: JONES,SUE MHSS RECORD POSTING DATES: APR 24, 1997 TO APR 24, 1997			
POSTING DATE	# FORMS		

APR 24, 1997	3		

Totals for JONES,SUE	3		

Grand Total for ALL Operators:	3		
Enter RETURN to continue or '^' to exit:			
JUN 13,1997 Page 2			
SUMMARY OF FORMS KEYED BY ALL OPERATORS MHSS RECORD POSTING DATES: APR 24, 1997 TO APR 24, 1997			
Operator	Forms	No. of Forms per day	% of Workload

GILL,SUSAN	3	3.0	100.0

	3		
RUN TIME (H.M.S): 0.0.0			
Enter RETURN to continue or '^' to exit:			

Number/Summary of Forms Keyed Screen

3.0 Reports Menu

The Reports Menu of the Mental Health and Social Services package provides numerous options for retrieving data from the patient file. Specific patient information and tabulations of records and visits can be obtained from the database. Options are provided for predefined reports and custom reports.

- **To access the Reports Menu, type “RPTS” at the IHS Mental Health/Social Services System Main Menu and press <RETURN>.**

The Reports Menu will be displayed. The Reports Menu contains six different submenus that categorize the reports by type. The first four submenus contain report options specific to the Mental Health/Social Services package. Use the last submenu to print standard tables applicable to this package. Each of these submenus and their report options are detailed in the following sections.

```
*****
**      IHS Mental Health/Social Services System  **
**                               Reports           **
*****
                               Version 2.0

                        ALBUQUERQUE HOSPITAL

                        **SPECIAL NOTE**

**Q-Man and PCC MGT Reports operate off PCC Files**
**Therefore, reflecting only those MH/SS visits passed to PCC**

PAT      Patient Listings ...
REC      MH/SS Record/Encounter Reports ...
WL       Workload/Activity Reports ...
PROB    Problem Specific Reports ...
PCCM    PCC Management Reports ...
QMAN    Q-Man (PCC Query Utility)
TABL    Print Standard MH/SS Tables ...
```

Reports Menu

You may access the PCC Management Reports module and Q-Man, an ad-hoc query tool, directly from the Reports Menu. These options generate reports from the PCC and will retrieve only Mental Health/Social Services data that has been passed to the PCC. PCC Management Reports and Q-Man will not be covered in this manual. Refer to their respective user manuals if you use these options.

Many of the Mental Health/Social Services reports use two common actions that allow you to select the records or visits to include in reports and to view data on the screen. Detailed instructions for performing these actions are provided below.

Using the Browser List

When you select specific patient visits or records to include in the report you generate a list browser similar to the one displayed below. The list browser is also used to select print and sort items for custom reports.

The action items available for using this menu are the following:

- | | |
|-------------------|-----------------------|
| + Next Screen | Q Quit Item Selection |
| - Previous Screen | R Remove Items |
| S Select Items | E Exit Report |
| ?? More Actions | |

MH/SS GENERAL RETRIEVAL Jan 31, 1997 10:49:18 Page:1
PATIENT Selection Menu

Patients can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all patients hit Q.

1) Sex	12) Medicaid Eligibility	23) Pts seen at a Locati
2) Patient Age	13) Priv Ins Eligibility	24) Pts Seen in a Commun
3) Patient DOB	14) Patient Flag Field	25) Pts w/Problem (DX)
4) Patient DOD	15) Case Open Date	26) Pts w/Problem (MHSS)
5) Living Patients	16) Case Admit Date	27) Pts seen by a Provid
6) Chart Facility	17) Case Closed Date	28) Pts seen for an Acti
7) Community of Residen	18) Case Disposition	29) Pts seen w/Axis IV L
8) Tribe of Membership	19) Next Case Review Dat	30) Pts w/Inpatient Disp
9) Eligibility Status	20) Designated MH Provid	
10) Class/Beneficiary	21) Designated SS Provid	
11) Medicare Eligibility	22) Personal History Ite	

Enter ?? for more actions

S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report

Select Action: S//

Patient Selection Menu

- Type “+” and “-“ at the “Select Action:” prompt to review the selection items in the list. In this case, the entire list fits on one screen so these actions are not necessary. With other lists, however, you must use the +/- keys to view all the items.

- When you are ready to select items, type “S” at the “Select Action:” prompt and press <RETURN>.
- Type any combination of the data items in the list (e.g., type a list or a range of numbers at the next prompt (1-4,5,20 or 10,12,20,28)).
- Type values for the items you selected, as applicable (e.g., if you selected age, enter an age range). See the sample screen below.

OR

- To include all records, type “Q” at the “Select Action:” prompt to bypass this step in the report-generation process.

NOTE: When you generate custom reports, select items in the same way, with some minor differences. If you select print items, you do not select any values. If you select a sort variable, type only one selection from the list. Usually, if you bypass the sort selection list, the report will be sorted by patient name or visit date.

```
Select Action: S// S Select Item(s)

Which patient item(s): (1-30): 2,7,20
2) Patient Age Selection.
Enter a Range of numbers (e.g. 5-12,1-1): 25-45
7) Community of Residence Selection.

Enter COMMUNITY: TUCSON      PIMA  ARIZONA  077  0410077
Enter ANOTHER COMMUNITY: SELLS      PIMA  ARIZONA  067  0410067
Enter ANOTHER COMMUNITY: <RETURN>

The following have been selected =>
  SELLS
  TUCSON
Want to save this COMMUNITY group for future use? No// <RETURN> (No)

20) Designated MH Provider Selection.
ENTER Designated MH Provider: DOUGLAS,BILL      BD
ENTER Designated MH Provider: <RETURN>

  PATIENT Selection Criteria
    Patient Age: 25-45
    Community of Residence: SELLS ; TUCSON
    Designated MH Provider: DOUGLAS,BILL
Hit return to continue...: <RETURN>
```

After you select and define the criteria, the Item List will be displayed. The items you selected will be marked with an asterisk (*).

3.1 Patient Listings

The Patient Listings submenu contains report options for generating lists of patients by various criteria. Also included is the Patient General Retrieval option, which is a custom report that allows you to select which patients to include in the report as well as the items to print and the sort criteria.

- **To view the Patient Listings Menu, type “PAT” at the “Select Reports Menu Option:” prompt and press <RETURN>.**

The Patient Listings Menu will be displayed. The options in this menu are detailed in the following subsections.

```
*****
**      IHS Mental Health/Social Services System      **
**                               Patient Listings      **
*****
                               Version 2.0

                        ALBUQUERQUE HOSPITAL

ACL      Active Client List
PGEN     Patient General Retrieval
DP       Designated Provider List
GRT      Patients with AT LEAST N Visits
ACO      Active Client List Using Case Open Date
AGE      Patients Seen by Age and Sex
PERS     Patient List for Personal Hx Items
SEEN     Cases Opened But Patient Not Seen in N Days
TCD      Tally Cases Opened/Admitted/Closed

Select Patient Listings Option:
```

Patient Listing Menu

3.1.1 Active Client List

- To print a list of patients seen at your facility between specified dates, type "ACL" at the "Select Patient Listing Option:" prompt in the Patient Listings Menu and press <RETURN>.

The Active Client List Screen will be displayed.

***** ACTIVE CLIENT LIST *****

This report will produce a list of patients who have been seen in a date range specified by the user.

Please enter the date range during which the patient should be seen in order to be considered active.

Enter beginning Date: April 24, 1997 (APR 24, 1997)

Enter ending Date: (4/24/97 - 6/19/97): APR 24, 1997// (APR 24, 1997)

Limit the list to those patients who have seen a particular provider? N// O

Select one of the following:

- P PRINT Output
- B BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>

Active Client List Screen

- Type the date you want to begin printing the Active Client List at the "Enter beginning Date:" prompt and press <RETURN>.
- Type the date you want to stop printing the Active Client List at the "Enter ending date:" prompt and press <RETURN>.

NOTE: Any patient seen at your facility within the time frame entered will be considered "active" and will be included in the report.

- Type "N" (No) or "Y" (Yes) next to the "Limit the list to those patients who have seen a particular provider?" prompt to indicate if you want to limit the report to one specific provider or include all providers at your facility.

- If you enter “Y”, type the provider’s name next to the “Enter provider name:” prompt and press <RETURN>.
- Type the corresponding letter of the output you want displayed on your screen next to the “Do you wish to:” prompt and press <RETURN>.
- Type a print device at the “Device:” prompt and press <RETURN>.

The Active Client List Report will print, as displayed below.

***** CONFIDENTIAL PATIENT INFORMATION *****							
Page 1							
SELLS HOSPITAL/CLINIC							
ACTIVE CLIENT LIST							
PROVIDER: ALL							
ENCOUNTER DATES: JAN 01, 1997 TO JAN 14, 1997							
PATIENT NAME	CHART NUMBER	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS
BROWN,BENJAMIN	101924	M	01/01/89	SELLS HOSP	DOUGLAS,BI	303.91 309.81	1
CARPENTER,HANNA	100150	F	01/03/23	HOME SELLS HOSP	BUTCHER,SA CURTIS,CLA DOUGLAS,BI	95 311. 42.1	6
CARTER,BROOKE	101434	F	08/13/77	SELLS HOSP	BUTCHER,SA DOUGLAS,BI	53	2
CARTER,MARY	100117	F	03/18/52	SELLS HOSP	DOUGLAS,BI JARLAND,TO	11 300.00 311.	3
FARMER,DON	100308	M	03/15/39	SELLS HOSP	DOUGLAS,BI	311.	1
FLINTSTONE,TERR	100233	F	11/06/31	SELLS HOSP	DOUGLAS,BI NYE,PATRIC	69 314.01	2
GREEN,HELEN	100203	F	04/16/51	SELLS HOSP	DOUGLAS,BI	307.80	1
JACKSON,MADGE	100038	F	02/08/53	SELLS HOSP	JARLAND,TO	23 311.	2
JOHNSON,MARTH	100085	F	01/01/06	SELLS HOSP	DOUGLAS,BI	312.30	1
JONES,CHESTER	102487	M	01/16/38	SELLS HOSP	BUTCHER,SA DOUGLAS,BI	96 300.00	2

Active Client List

3.1.2 Patient General Retrieval

- To create your own report to list or count patients, type "PGEN" at the "Select Patient Listing Option:" prompt in the Patient Listings Menu and press <RETURN>.

The Mental Health/Social Services Encounter General Retrieval Screen will be displayed. Use this screen to select which patients to include in the report, which data items to print, and how the data is sorted. You may generate a very specific report or a very general report. You may limit your search to predefined templates of patients that have been created with Q-Man, Case Management, or other RPMS tools.

MENTAL HEALTH/SOCIAL SERVICES ENCOUNTER GENERAL RETRIEVAL

This report will produce a listing of Patients in a date range selected by the user. The Patients printed can be selected based on any combination of items. The user will select these items. The items printed on the report are also selected by the user.

If selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

Select one of the following:

S	Search Template
P	Patient File

Select and Print Patient List from: P Patient File

Do you want to use a PREVIOUSLY DEFINED REPORT? N// O

Mental Health/Social Services Encounter General Retrieval Screen

- Type the corresponding letter of the type of output you want displayed on your screen next to the "Select and Print Patient List from:" prompt and press <RETURN>.
- If you want to search the entire Mental Health/Social Services patient file, type "S" and press <RETURN>.

Enter the name of the template. After you enter the name of the template, select print items and a sort item. To do so, follow the directions in the corresponding sections below.

- If you want to limit your report to a search template of patients that has already been created, type “P” at the “Select and Print Patient List from:” prompt and press <RETURN>.

Enter the report name and the report will generate with no further actions required. If you create a new report, follow the directions in Section 3.1.2.1, Selecting Search Criteria, below.

3.1.2.1 Selecting Search Criteria

Use this option to search the patient file to create a new report. Use this referral selection list to browse.

- Type “N” (No) at the “Do you want to use a Previously Defined Report?” prompt and press <RETURN>.

The Patient Selection Menu will be displayed.

MHSS GENERAL RETRIEVAL Jun 19, 1997 14:03:09 Page: 1 of 1		
PATIENT Selection Menu		
Patients can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all patients type Q.		
1) Sex	12) Medicare Eligibility	23) Personal History Ite
2) Patient Age	13) Medicaid Eligibility	24) Pts seen at a Locati
3) Patient DOB	14) Priv Ins Elibility	25) Pts Seen in a Commun
4) Patient DOD	15) Patient Flag Field	26) Pts w/Problem (DX)
5) Living Patients	16) Case Open Date	27) Pts w/Problem (MHSS
6) Chart Facility	17) Case Admit Date	28) Pts seen by a Provid
7) Community of Residen	18) Case Closed Date	29) Pts w/Education Done
8) County of Residence	19) Case Disposition	30) Pts seen for an Acti
9) Tribe of Membership	20) Next Case Review Dat	31) Pts seen w/Axis IV L
10) Eligibility Status	21) Designated MH Provid	32) Pts w/Inpatient Disp
11) Class/Beneficiary	22) Designated SS Provid	
Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Patient Selection Menu

- After you select the patients to include in the report, type “Q” at the “Select Action:” prompt and press <RETURN>.

3.1.2.2 Selecting the Report Type

Use this option to indicate the type of report you want to generate. This option is displayed after you have entered patients in the Patient Selection Menu (directly above).

Select one of the following:

T	Total Count Only
S	Sub-counts and Total Count
D	Detailed Listing

Choose Type of Report: D// <RETURN>

- Type the corresponding letter of the type of report you want to print at the “Choose Type of Report:” prompt and press <RETURN>.

T Total Count Only. This report prints only the total number of patients that match the selection criteria selected. If you select this report option, no further actions will be needed to generate the report.

S Sub-Counts and Total Count. The Sub-counts and Total Count Report lists the total number of matches and the subtotal of each different category of the sort variable selected (e.g., if you sort the report by sex, the number of males, the number of females, and the total number of patients in the group will print). If you select this report type, the Sort Item Selection Menu will be displayed (see Section 3.1.2.4, Selecting a Sort Category).

D Detailed Listing. Use this option to create a report that prints only the data items you need sorted by the variable selected. A total patient count is also included.

NOTE: If you use a previously defined report, the Report Type Menu will **not** be displayed. The report type that prints will be the same one that was saved.

3.1.2.3 Selecting Print Items

Use this option to list data items that can be printed if you select the Detailed Patient Listing report type detailed in Section 3.1.2.2, Selecting the Report Type, above.

- Type "D" at the "Choose type of report:" prompt and press <RETURN>.

The Print Item Selection Menu will be displayed. This menu lists data items that can be printed.

MHSS GENERAL RETRIEVAL		Jun 19, 1997 15:36:53	Page: 1 of 1
PRINT ITEM SELECTION MENU			
The following data items can be printed. Choose the items in the order you want them to appear on the printout. Keep in mind that you have an 80-column screen available, or a printer with either 80 or 132 column width.			
1) Patient Name	11) Eligibility Status	21) Case Open Date	
2) Sex	12) Class/Beneficiary	22) Case Admit Date	
3) Patient Age	13) Medicare Eligibility	23) Case Closed Date	
4) Patient DOB	14) Medicaid Eligibility	24) Case Disposition	
5) Patient SSN	15) Priv Ins Eligibility	25) Next Case Review Dat	
6) Patient DOD	16) Mailing Address-City	26) Designated MH Provid	
7) Patient Chart #	17) Home Phone	27) Designated SS Provid	
8) Community of Residen	18) Mother's Name	28) Personal History Ite	
9) County of Residence	19) Patient Flag Field		
10) Tribe of Membership	20) Patient Flag Narrati		
Enter ?? for more actions			
S	Select Item(s)	+ Next Screen	Q Quit Item Selection
R	Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//			

Print Item Selection Menu

- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the print items and specify a column width for each one, press <RETURN>.
- Type "Q" at the "Select Action:" prompt in the Print Selection Menu and press <RETURN>.

The Sort Item Selection Menu (see Section 3.1.2.4, Selecting a Sort Category) will be displayed.

3.1.2.4 Selecting a Sort Category

Use this option to select a sort variable (when you create a Detailed Report Listing or a Sub-counts and Total Counts Report). This option is displayed when you exit the Print Selection Menu, above.

NOTE: If you do not choose a variable, the report will be sorted by Patient Name.

- To select a sort variable, follow the procedures outlined on in the introduction to this section.

MHSS GENERAL RETRIEVAL			Jun 19, 1997 15:54:27	Page: 1 of 1
SORT ITEM SELECTION MENU				
The patients displayed can be SORTED by ONLY ONE of the following items. If you don't select a sort item, the report will be sorted by patient name.				
1) Patient Name	6) Community of Residen	11) Patient Flag Field		
2) Sex	7) County of Residence	12) Designated MH Provid		
3) Patient DOB	8) Tribe of Membership	13) Designated SS Provid		
4) Patient DOD	9) Eligibility Status			
5) Patient Chart #	10) Class/Beneficiary			
Enter ?? for more actions				
S	Select Item(s)	+	Next Screen	Q Quit Item Selection
R	Remove Item(s)	-	Previous Screen	E Exit Report
Select Action: S//				

Sort Item Selection Menu

You may also use this option to print each sort item category on a separate page, add a custom title to the report, and save the report for future use.

- Type "S" at the "Select Action:" prompt in the Sort Item Selection Menu and press <RETURN>.

The "Sort Patients by which of the above:" prompt will be displayed.

- Type the number of the option by which you want to sort at the "Sort Patients by which of the above:" prompt and press <RETURN>.

The following questions will be displayed.

Do you want a separate page for each Patient Name? N// O
Would you like a custom title for this report? N// O
Do you wish to SAVE this SEARCH/PRINT/SORT logic for future use? N// O

- Type "Y" (Yes) or "N" (No) to each question and press <RETURN> after each response.

The Mental Health and Social Services Patient Listing Report will print, as displayed below. The selection, print, and sort criteria are detailed on the cover page that prints with every report, as shown here.

MENTAL HEALTH AND SOCIAL SERVICES PATIENT LISTING						
REPORT REQUESTED BY: CHARTS,MONICA						
The following report contains a Patient report based on the following criteria:						
PATIENT Selection Criteria						
Patient Age: 15-30						
Community of Residence: TUCSON						
PRINT Field Selection						
Patient Name (15)						
Sex (6)						
Patient Age (4)						
Patient Chart # (8)						
Tribe of Membership (14)						
Designated MH Provider (18)						
TOTAL column width: 65						
Patients will be sorted by: Patient Name						
***** CONFIDENTIAL PATIENT INFORMATION *****						
MH/SS PATIENT LISTING						Page 1
PATIENT NAME	SEX	AGE	HRN	TRIBE OF MEMBE	DESIGNATED MH PROV	

ADAMS,YOLANDA	FEMALE	29	SE100867	TOHONO O'ODHAM	CARLSON,BILL	
CARPENTER,CLARE	MALE	18	SE101601	TOHONO O'ODHAM	CARLSON,BILL	
FARMER,WILMA	FEMALE	28	SE100955	TOHONO O'ODHAM	STEWART,MAR	
GREENJEANS,JANE	FEMALE	29	SE102805	TOHONO O'ODHAM	CARLSON,BILL	
GREENJEANS,JIM	MALE	29	SE101043	TOHONO O'ODHAM	STEWART,MARTIN	
HANCOCK,JUNE	FEMALE	25	SE601719	TOHONO O'ODHAM	STEWART,MARTIN	
JEFFERSON,CORRI	FEMALE	24	SE102306	TOHONO O'ODHAM	CARLSON,BILL	
JONES,HUGH	MALE	30	SE102041	NAVAJO TRIBE	CARLSON,BILL	
Total Patients: 11						
RUN TIME (H.M.S): 0.0.2						
End of report. HIT RETURN:						

Mental Health and Social Services Patient Listing

3.1.3 Designated Provider List

- To list and count the clients for an individual Designated Provider, type "DP" at the "Select Patient Listing Option:" prompt in the Patient Listings Menu and press <RETURN>.

The Designated Provider Screen will be displayed.

```

                                DESIGNATED PROVIDER LIST

Select one of the following:
M      MENTAL HEALTH
S      SOCIAL SERVICES
O      OTHER

Which DESIGNATED PROVIDER: M// <RETURN>

Select one of the following:
1      ONE PROVIDER
2      ALL PROVIDERS

Run Report for: 1// 2 <RETURN>

Select one of the following:
P      PRINT Output
B      BROWSE Output on Screen

Do you wish to : P// <RETURN>

```

Designated Provider List

- Type the requested information at each prompt and press <RETURN> to record your entries.
- Type the corresponding letter of the print option you want at the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Designated Provider List will print, as displayed below.

***** CONFIDENTIAL PATIENT INFORMATION *****					
Page 1					
SELLS HOSPITAL/CLINIC					
DESIGNATED MENTAL HEALTH PROVIDER LIST					
PROVIDER: ALL					
PATIENT NAME	CHART #	SEX	DOB	COMMUNITY	LAST VISIT

PROVIDER: DOUGLAS,BILL					
ADAMS,ROSE	306198	F	01/01/62	SELLS	10/13/95
FLINTSTONE,DIANE	100306	F	10/21/35	RIPLEY	07/21/94
JACKSON,BRUCE	102049	M	02/10/89	LITTLE TUCS	10/07/96
RUBBLE,ALAN	102388	M	12/03/72	VENTANA	01/29/96
SMITH,BOB	101846	M	02/04/88	LITTLE TUCS	01/07/97
WRIGHT,MANDY	100006	F	01/01/70	TUCSON	12/28/96
SUB-TOTAL: 6					
PROVIDER: MARTINEZ,NANCY					
BARTZOK,LAURIE	345593	F	06/21/57	TUCSON	09/22/94
GRANT,HELEN	102706	F	04/27/23	TOPAWA	11/23/95
SUB-TOTAL: 2					
End of report. HIT RETURN:					

Designated Provider List

3.1.4 Patients with at Least N Visits

- To print a list of patients who have been seen an minimum number of times within a specified date range, type "GRT" at the "Select Patient Listing Option:" prompt in the Patient Listings Menu and press <RETURN>.

The Patients Seen at Least N Number of Times Screen will be displayed.

***** PATIENTS SEEN AT LEAST N NUMBER OF TIMES *****

This report will produce a list of patients who have been seen at least N number of times in a date range specified by the user.

Please enter the date range during which the patient should be seen.

Enter beginning Date: April 24, 1997 (APR 24, 1997) <RETURN>

Enter ending Date: (4/24/97 - 6/19/97): APR 24, 1997// (APR 24, 1997) <RETURN>

Enter the minimum number of times the patient should have been seen: (2-100): 2

Select one of the following:

P	PRINT Output
B	BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>

- Type the date you want to begin printing at the "Enter beginning Date:" prompt and press <RETURN>.
- Type the date you want to stop printing at the "Enter ending Date:" prompt and press <RETURN>.
- Type the minimum number of visits for a patient during this time period at the "Enter the minimum number of times the patient should have been seen:" prompt and press <RETURN>.

NOTE: When you enter the minimum number of visits, you are assigning a value to N. Any patient who has been seen at least the number of times equal to the value of N will be included in the report.

- Type the corresponding letter of the print option you want at the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Patient Seen at Least N Times Report will print, as displayed below.

Page 1								
SELLS HOSPITAL/CLINIC								
PATIENTS SEEN AT LEAST 5 TIMES								
RECORD DATES: JAN 01, 1996 TO DEC 31, 1996								
PATIENT NAME	CHART #	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS	
ADAMS,ADAM	600214	M	10/04/84	SELLS HOSP	CISCO,SID DOUGLAS,BI	10	5	
BROEN,LENOR	100182	F	11/08/34	MOBILE HEA SELLS HOSP	MARTINE,N	30 39	5	311.00
BURR,JOANNE	100185	F	01/01/42	MOBILE HEA SELLS HOSP	MARTINEZ,N DOUGLAS,BI ROANHORSE,	2 30 39 40	7	301.00
CARTER,BEA	102261	F	11/10/53	SELLS HOSP SELLS OTHE	DOUGLAS,BI EMERSON,MA	2 53 60 78	6	311.00
RUN TIME (H.M.S): 0.0.0								
End of report.								

Patients Seen at Least N Times Report

3.1.5 Active Client List Using Case Open Date

- To generate a list of patients who have a Case Open Date, but not a Case Closed Date, type "ACO" at the "Select Patient Listing Option:" prompt in the Patient Listings Menu and press <RETURN>.

The Active Client List (Using Case Open Date) Screen will be displayed. The encounter date range for this report is calculated from one year ago (T - 365 days) to the present date (T). Any cases that were opened during this time period and do not have a Case Closed Date entered into the system are classified as "open" and will be listed on this report.

```
***** ACTIVE CLIENT LIST (USING CASE OPEN DATE) *****  
  
This report will produce a list of patients who have a case open date without a case closed  
date.  
  
Select one of the following:  
P    PRINT Output  
B    BROWSE Output on Screen  
  
Do you wish to : P// RINT Output  
DEVICE: HOME// <RETURN>
```

Active Client List (Using Case Open Date) Screen

- Type the corresponding letter of the print option you want at the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the “Device:” prompt and press <RETURN>.

The Active Client List will print, as displayed below.

***** CONFIDENTIAL PATIENT INFORMATION *****									
Page 1									
WHITE EARTH HEALTH CENTER									
Encounter Dates: JAN 22, 1996 to JAN 21, 1997									
ACTIVE CLIENT LIST (CASE OPEN DATE WITH NO CASE CLOSED DATE)									
PATIENT NAME	CHART NUMBER	SEX	DOB	CASE OPEN DATE	CASE DATE	ADMIT	PROVIDER	PROBLEM	CODES
BROWN,AUGUST	385656	M	12/17/34	05/03/96			DOUGLAS,BI	94	
								780.9	
FRANKEN,BEV	496879	F	07/17/50	08/21/96			DOUGLAS,BI	79	
								300.0	
KAFKA,BERNIE	495224	M	12/25/48	10/30/96			ROANHORSE,	53	
								60	
LOOMIS,STEPH	439090	F	02/20/75	12/21/96			CISCO,SID	2	
SMITH,BERNICE	398555	F	06/28/61	01/03/97			MARTINEZ,N	10	
RUN TIME (H.M.S): 0.0.1									
End of report.									

Active Client List

3.1.6 Patients Seen by Age and Sex

- To generate a list of patients who have had a Mental Health or Social Services visit within a certain time frame, type "AGE" at the "Select Patient Listing Option:" prompt in the Patient Listings Menu and press <RETURN>.

The MH/SS Patient Contacts by Age and Sex Screen will be displayed. The numbers displayed in this report are categorized by age and sex.

MH/SS Patient Contacts by Age and Sex

This report will tally the number of patients, who have had an encounter, by age and sex. You will choose the item you wish to tally. For example, you can tally problems treated, or activities by age and sex.
NOTE: Any tally by PROBLEM only includes PRIMARY PROBLEM. You will also be able to define the age groups to be used.

- 1). Program Type
- 2). POV/Problem (Problem Code)
- 3). Problem/POV (Problem Category)
- 4). Problem/POV
- 5). Location of Service
- 6). Type of Contact of Visit
- 7). Activity Code
- 8). Activity Category
- 9). Community of Service

<The item you pick will display down the left column of the report, Age groups will be across the top.>

Choose an item to tally by age and sex: (1-9): 2 <RETURN>

Enter beginning Contact Date for Search: April 24, 1997 (APR 24, 1997)

Enter ending Contact Date for Search: (4/24/97 - 6/20/97): APR 24, 1997//

MH/SS Patient Contacts by Age and Sex Screen

- Type the category (item) by which you want to tally the patient data (e.g., tally patients by program type or location of service) at the "Choose an item to tally by age and sex:" prompt and press <RETURN>.
- Type the date you want to begin searching at the "Enter beginning Contact Date for Search:" prompt and press <RETURN>.

- Type the date you want to stop searching at the “Enter ending Contact Date for Search:” prompt and press <RETURN>.

NOTE: Patients must have had a Mental Health/Social Services visit within the time frame you enter above to be counted in this report.

The Visit Selection Menu will be displayed. Type “+” at the “Select Action:” prompt to view the entire Visit Selection Menu.

MHSS GENERAL RETRIEVAL Jun 20, 1997 11:32:05 Page: 1 of 2

VISIT Selection Menu

Contacts can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all contacts type Q.

1) Patient Name	21) Case Disposition	41) Axis V
2) Patient Sex	22) Next Case Review Dat	42) Flag (Local Use)
3) Patient Age	23) Appointment/Walk-In	43) Primary Provider
4) Patient DOB	24) Interpreter Utilized	44) Primary Prov Discipl
5) Patient DOD	25) Program	45) Primary Prov Affilia
6) Living Patients	26) Location of Encounte	46) Prim/Sec Providers
7) Chart Facility	27) Clinic	47) Prim/Sec Prov Discip
8) Patient Community	28) Outside Location	48) POV (Prim or Sec)
9) Patient County Resid	29) SU of Encounter	49) POV (Prob Code Grps)
10) Patient Tribe	30) County of Service	50) Primary POV
11) Eligibility Status	31) Community of Service	51) POV (Problem Categor
12) Class/Beneficiary	32) Eval&Man CPT	52) POV Diagnosis Catego
13) Medicare Eligibility	33) Activity Type	53) Axis I/II Diagnoses
14) Medicaid Eligibility	34) Activity Category	54) Procedures (CPT)
15) Priv Ins Elibility	35) Number Served	55) Education Topics Pro
16) Patient Encounters O	36) Type of Contact	56) Personal History Ite
17) Patient Flag Field	37) Activity Time	57) Designated MH Prov
18) Case Open Date	38) Inpatient Dispositio	58) Designated SS Provid
19) Case Admit Date	39) PCC Visit Created	
20) Case Closed Date	40) Axis IV	

+ Enter ?? for more actions

S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report

Select Action: S//

Visit Selection Menu

- Type “S” at the “Select Action:” prompt and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.

- After you select the data items and enter the requested information for each item, press <RETURN>.
- Type "Q" at the "Select Action:" prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed.

```
The Age Groups to be used are currently defined as:
0 - 0
1 - 4
5 - 14
15 - 19
20 - 24
25 - 44
45 - 64
65 - 125

Do you wish to modify these age groups? Y <RETURN>

Enter the starting age of the first age group: (0-150): 1
Enter the starting age of the next age group: (0-150): 25

Select one of the following:
P    PRINT Output
B    BROWSE Output on Screen

Do you wish to : P// <RETURN>
```

- Type "Y" (Yes) or "N" (No) at the "Do you wish to modify these age groups?" prompt to indicate if you want to modify the age groups and press <RETURN>. If you type "Y", enter the requested information at the prompts that follow.
- Type the corresponding letter of the print option you want at the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Mental Health/Social Services Record Listing Screen will print, as displayed below. The report printout includes three reports. All patients will be tallied by age for the category you selected. The figures will also be reported separately for females and males. A cover page that displays the report criteria prints as the first page.

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING									
REPORT REQUESTED BY: DOUGLAS,BILL									
The following visit listing contains MH/SS records selected based on the following criteria:									
RECORD SELECTION CRITERIA									
Encounter Date range: JAN 01, 1997 to JAN 21, 1997									
Patient Tribe: TOHONO O'ODHAM NATION OF ARIZONA									
Report Type: RECORD COUNTS BY AGE/SEX									
***** CONFIDENTIAL PATIENT INFORMATION *****									
MENTAL HEALTH AND SOCIAL SERVICES RECORD/ENCOUNTER COUNTS JAN 21,1997 Page 1									
COMMUNITY OF SERVICE BY AGE AND SEX									
ENCOUNTER DATES: JAN 01, 1997 TO JAN 21, 1997									
SEX: BOTH									
COMMUNITY OF SERVICE	0-0	1-4	5-14	15-19	20-24	25-44	45-64	65-125	TOTAL

AJO	.	1	3	2	7	5	1	2	21
BIG FIELDS	.	.	.	2	1	.	1	.	4
PISINIMO	.	.	1	.	.	3	2	.	6
RIPLEY	.	.	.	1	.	2	4	.	7
SAN XAVIER	.	1	1	2	3	6	2	1	16
SANTA ROSA	1	4	1	1	7
SELLS	.	2	.	3	1	2	1	2	11
TUCSON	.	2	2	3	3	6	4	1	21
TOTAL:									93
SEX: FEMALE									
COMMUNITY OF SERVICE	0-0	1-4	5-14	15-19	20-24	25-44	45-64	65-125	TOTAL

AJO	.	.	2	1	2	3	1	2	11
BIG FIELDS	.	.	.	1	1	.	1	.	3
PISINIMO	.	.	1	.	.	1	.	.	2
RIPLEY	2	4	.	6
SAN XAVIER	.	1	1	.	1	4	2	1	10
SANTA ROSA	1	2	.	1	4
SELLS	.	1	.	1	.	2	1	1	6

Mental Health/Social Services V 2.0
User's Manual

TUCSON	.	1	1	2	2	2	3	1	12
TOTAL:									54
SEX: MALE									
COMMUNITY OF SERVICE	0-0	1-4	5-14	15-19	20-24	25-44	45-64	65-125	TOTAL

AJO	.	1	1	1	5	2	.	.	10
BIG FIELDS	.	.	.	1	.	.	.	.	1
PISINIMO	.	.	.	.	.	2	2	.	4
RIPLEY	.	.	.	1	.	.	.	.	1
SAN XAVIER	.	.	.	2	2	2	.	.	6
SANTA ROSA	.	.	.	.	.	2	1	.	3
SELLS	.	1	.	2	1	.	.	1	5
TUCSON	.	1	1	1	1	4	1	.	9
TOTAL:									39

Mental Health/Social Services Record Listing

3.1.7 Patient List for Personal Hx Items

- To print a list of personal history items for patients in the Mental Health or Social Services file, type “PERS” at the “Select Patient Listing Option:” prompt in the Patient Listings Menu and press <RETURN>.
- Type a print device at the “Device:” prompt and press <RETURN>.

A Personal History Patient Listing will print. Each patient's sex, age, and chart number are displayed.

CHART	PATIENT	SEX	AGE	NUMBER
PERSONAL HISTORY PATIENT LISTING JAN 15,1997 12:34 PAGE 1				

FACTOR: CHILD ABUSE (VICTIM)				
	ADAMS,ROSE	FEMALE	45	103060
	BATES,LORI ANN	FEMALE	37	108942
	CULLER,LOUISE	FEMALE	29	106733
	DEBATER,MARY	FEMALE	35	107895
	ENERTS,SHEILA	FEMALE	42	106675
	GERTZ,TONYA	FEMALE	67	101136

SUBCOUNT 6				
FACTOR: PARTNER ABUSE (VICTIM)				
	HERNANDEZ,GUADALUPE	FEMALE	21	100072
	WATERMAN,ANNETTE	FEMALE	48	100746

SUBCOUNT 2				
FACTOR: SUBSTANCE ABUSE				
	CARTER,AMANDA	FEMALE	67	101136
	MILLER,DAN	MALE	63	102483
	MUSTARD,CURT	MALE	41	102230

SUBCOUNT 3				

COUNT	11			

Personal History Patient Listing Screen

3.1.8 Cases Opened But Patient Not Seen in N Days

- To print a list of patients with open cases who have been admitted, but not seen by a provider in a specified number of days, type "SEEN" at the "Select Patient Listing Option:" prompt in the Patient Listings Menu and press <RETURN>.

The Active Client List (Open/Admitted But Not Seen in N Days) Screen will be displayed.

```
***** ACTIVE CLIENT LIST (OPEN/ADMITTED BUT NOT SEEN IN N DAYS) *****

This report will produce a list of patients who have a case open date, optionally, an admit date, no
closed date, and have not been seen in N days. The user will determine the number of days to use.

Select one of the following:
  O   Opened - Not Admitted
  A   Admitted

Include Cases that are: O// pened - Not Admitted

Select one of the following:
  A   Any Provider
  O   One Provider

Include cases opened by: A// ny Provider
Enter the number of days since the patient has been seen: (1-99999): 15

Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>
```

Active Client List (Open/Admitted But Not Seen in N Days) Screen

- Type the corresponding letter of the type of list you want to print at the "Include Cases that are:" prompt and press <RETURN>.
- Type the corresponding letter of the type of provider information you want to print at the "Include cases opened by:" prompt and press <RETURN>.
- Type the number of days at the "Enter the number of days since the patient has been seen:" prompt and press <RETURN>.
- Type the corresponding letter of the print option you want at the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Active Client List (Case Open/Admit & Not Seen in N Days) Screen will print, as displayed below.

***** CONFIDENTIAL PATIENT INFORMATION *****								
Page 1								
ALBUQUERQUE HOSPITAL								
ACTIVE CLIENT LIST (CASE OPEN /ADMIT & NOT SEEN IN 15 DAYS)								
PATIENT NAME	CHART NUMBER	SEX	DOB	CASE OPEN DATE	CASE ADMIT DATE	DATE LAST SEEN	# DAYS SINCE	
GERRY,JOE	12031	M	01/20/31	04/24/97			not seen	
GERRY,JOE	12031	M	01/20/31	04/24/97			not seen	
DONALD,JIM	121212	M	07/30/53	04/25/97			not seen	
DONALD,JIM	121212	M	07/30/53	04/30/97			not seen	
Total Number of Patients: 2								
Total Number of Cases: 4								
RUN TIME (H.M.S): 0.0.0								
End of report. PRESS RETURN:								

Active Client List (Case Open/Admit & Not Seen in N Days) Screen

3.1.9 Tally Cases Opened/Admitted/Closed

- To print a list of the case open, admit, and closed dates in a time period, type "TCD" at the "Select Patient Listing Option:" prompt in the Patient Listings Menu and press <RETURN>.

The Tally of Cases Opened, Admitted, Closed in a Time Frame Screen will be displayed.

```
***** TALLY OF CASES OPENED, ADMITTED, CLOSED IN A TIME FRAME *****

This report will produce a tally of the case open, admit and closed dates in a time period.

Enter beginning of Time Period: Jan 1, 1996 (JAN 01, 1996)

Enter end of Time Period: (1/1/96 - 6/20/97): JAN 01, 1996// May 30, 1997 (MAY 30, 1997)

Select one of the following:
  A   Any Provider
  O   One Provider

Include cases opened by: A// ny Provider

Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// <RETURN>

DEVICE: HOME// <RETURN>
```

Tally of Cases Opened, Admitted, Closed in a Time Frame Screen

- Type the date you want to begin tallying cases at the "Enter beginning of Time Period:" prompt and press <RETURN>.
- Type the date you want to stop tallying cases at the "Enter end of Time Period:" prompt and press <RETURN>.
- Type the corresponding letter of the print option you want at the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the “Device:” prompt and press <RETURN>.

The Tally of Cases Opened/Admitted/Closed Report will print, as displayed below.

ALBUQUERQUE HOSPITAL TALLY OF CASES OPENED/ADMITTED/CLOSED	
Number of Cases Opened:	6
Number of Cases Admitted:	2
Number of Cases Closed:	2
Tally of Dispositions:	
PATIENT DIED	1
PATIENT MOVED	1
RUN TIME (H.M.S): 0.0.0	
End of report. PRESS RETURN:	

Tally of Cases Opened/Admitted/Closed Report

3.2 MH/SS Record/Encounter Reports

Report options for listing various records from the Mental Health/Social Services patient file are available on the MH/SS Encounter/Record Reports Menu. Select from a standard output list, a custom retrieval tool, or a list of potentially billable visits. The options in the MH/SS Encounter/Record Reports Menu are detailed in the following sections.

- **To view the Encounter/Record Reports Menu, type “REC” at the “Reports Menu Option:” prompt and press <RETURN>.**

The Encounter/Record Reports Menu will be displayed.

```
*****  
**      IHS Mental Health/Social Services System      **  
**              Encounter/Record Reports              **  
*****  
                          Version 2.0  
  
                ALBUQUERQUE HOSPITAL  
  
LIST  List MH/SS Records, STANDARD Output  
GEN   List MH/SS Records, GENERAL RETRIEVAL Output  
BILL  Potentially Billable MH/SS Visits  
  
Select MH/SS Record/Encounter Reports Option:
```

Encounter/Record Reports Menu

3.2.1 List MH/SS Records, STANDARD Output

- To print a detailed or a brief listing of Mental Health and Social Services records, type “LIST” at the “Select MH/SS Record/Encounter Reports Option:” prompt and press <RETURN>.

The Mental Health/Social Services Record List Screen will be displayed.

```
***** Mental Health/Social Services Record List *****

This report will produce either a detailed, or brief listing of Mental Health and Social Services contacts.
The list of contacts will be for a date range specified by the user and contacts can be selected based on
any of the following items: Provider, Program, Provider Discipline, Problem Code, Activity Type, Type
of Contact, Patient Age, Patient Sex, Patient Tribe Patient Community, Community of Service, or
Location of Encounter. The user can select any number of these screens.

Enter beginning Contact Date for Search: January 1, 1996 (JAN 01, 1996)

Enter ending Contact Date for Search:(1/1/96-6/20/97):JAN 01,1996//May 30, 1997(MAY 30, 1997)

Record selection criteria:
Encounter Date range: JAN 01, 1996 to MAY 30, 1997.
```

Mental Health/Social Services Record List Screen

- Type the date you want to begin your search at the “Enter beginning Contact Date for Search:” prompt and press <RETURN>.
- Type the date you want to stop your search at the “Enter ending Contact Date for Search:” prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex). Use the screening criteria in the Visit Selection Menu below to select records for the report.

- Type “S” at the “Select Action:” prompt in the Visit Selection Menu and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.

- Type "Q" at the "Select Action:" prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed.

Report Print Selection.

Select one of the following:

D	Detailed (132 column print)
B	Brief (80 column print)

Type of Report to Print: D// <RETURN>

- Type the corresponding letter of the type of report you want to print at the "type of Report to Print:" prompt and press <RETURN>.

The Sort Item Selection Menu will be displayed (see Section 3.1.2.4, Selecting a Sort Category). Select one of the items in the Sort Item Selection Menu for sorting your report. If you do not make a selection, the report will be sorted by visit date.

- Type "S" at the "Select Action:" prompt in the Sort Item Selection Menu and press <RETURN>.
- Type the number of the data item you want to sort at the "Sort contacts by which of the above:" prompt and press <RETURN>.
- Type "Y" (Yes) or "N" (No) at the "Do you want a separate page for each Patient Name?" prompt and press <RETURN>.
- Type the corresponding letter of the print option you want at the "Do you wish to:" prompt and press <RETURN>.

- Type a print device at the "Device:" prompt and press <RETURN>.

The Mental Health/Social Services Record Listing will print, as displayed below. Each report includes a cover page that details the criteria selected.

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING							
REPORT REQUESTED BY: CISCO,SID							
The following visit listing contains MH/SS records selected based on the following criteria:							
RECORD SELECTION CRITERIA							
Encounter Date range: JAN 01, 1997 to JAN 31, 1997							
Patient Community: SANTA ROSA							
Report Type: STANDARD BRIEF OR DETAILED RECORD LIST							
***** CONFIDENTIAL PATIENT INFORMATION *****							
SELLS HOSPITAL/CLINIC						Page 1	
MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING							
Record Dates: JAN 01, 1997 and JAN 31, 1997							
=====							
DATE	PROV	LOC	PATIENT NAME	ACT	CONT	AT HRN	PROB NARRATIVE

01/28/97	MJS	SR	HALL,MONTY A	12	OUTP	20 SR 456763 311.	DEPRESS DISO
01/26/97	EDE	SR	IGNACIO,JOSE	11	OUTP	15 SR 459879	No Probs recorded
01/18/97	BD	SR	JACOBS,BILL	11	ADMI	20 SR 451223 33	MILD MENT RET
01/02/97	BD	SR	KUNZ,MARISEL	11	OUTP	28 SR 458956 309.28	ADJUST DISO
01/06/97	SC	SR	LABEER,SUZAN	11	OUTP	11 SR 453329 311.	DEPRESSIVE DISO
01/07/97	SC	SR	LINCOLN,BONN	13	OUTP	55 SR 458867 311.	DEPRESSED
							305.00 CURRENT DRINK
01/13/97	NM	SR	ROBERTS,AUDR	13	OUTP	30 SR 459963 305.00	ALCOHOL ABUSE,
01/06/97	BD	SR	SMITH,JAMIE	11	OUTP	20 SR 458814 311.	DEPRESS DISO
01/19/97	ACC	SR	SMITH,STEVEN	11	OUTP	20 SR 459778 311.	DEPRESS DISO
01/16/97	BD	SR	VON BRAUN,CH	13	CONS	55 SR 452287 39	SUICIDE
01/28/97	ACC	SR	WHEELWRIGHT,	22	OUTP	20 SR 108134 295.24	SCHIZOPHRENIA
RUN TIME (H.M.S): 0.0.1							
End of report. HIT RETURN:							

Mental Health/Social Services Record Listing

3.2.2 List MH/SS Records, GENERAL RETRIEVAL Output

- To print a list of contacts in a specified date range, type "GEN" at the "Select MH/SS Record/Encounter Reports Option:" prompt and press <RETURN>.

The Mental Health/Social Services Encounter General Retrieval Screen will be displayed. Use this screen to select which visits to count or list in the report as well as which data items print and how the data is sorted. Depending on the choices you make, you can generate a very specific report or a very general report. Also, you may limit your search to predefined templates of patients that have been created with Q-Man, Case Management, or other RPMS tools.

MENTAL HEALTH/SOCIAL SERVICES ENCOUNTER GENERAL RETRIEVAL

This report will produce a listing of contacts in a date range selected by the user. The contacts printed can be selected based on any combination of items. The user will select these items. The items printed on the report are also selected by the user.

If selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

Select one of the following:

S	Search Template
D	Date Range

Select and Print Encounter List from: D Date Range

Enter Beginning Encounter Date for search: January 1, 1996 (JAN 01, 1996)

Enter Ending Encounter Date for search: (1/1/96 - 6/23/97): JAN 01, 1996// April 24, 1997 (APR 24, 1997)

Do you want to use a PREVIOUSLY DEFINED REPORT? N// <RETURN>

Mental Health/Social Services Encounter General Retrieval Screen

- Type the corresponding letter of the type of report you want to print at the "Select and Print Encounter List from:" prompt, and press <RETURN>. You may specify whether to limit your search to a predefined template or to a certain date range. The example in the above screen uses a date range.

S Search Template. If you use a search template of patients, enter the name of the template. After you enter the template name, select print items and a sort variable. To do so, follow the directions in the corresponding sections below.

D Date Range. If you select to search the patient file for visits within a date range, type a beginning and ending date to define the range. Only visits that occurred within the time frame you specify will be included in the report.

- Type “Y” (Yes) or “N” (No) at the “Do you want to use a Previously Defined Report?” prompt.
- If you select an existing report, type “Y” at the “Do you want to use a Previously Defined Report?” prompt and press <RETURN>.

The report name and the report will generate with no further actions required.

OR

- If you create a new report, type “N” at the “Do you want to use a Previously Defined Report?” prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex). Use the screening criteria in the Visit Selection Menu to select records for the report.

- Type “S” at the “Select Action:” prompt in the Visit Selection Menu and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.
- Type “Q” at the “Select Action:” prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed.

Select one of the following: T Total Count Only S Sub-counts and Total Count D Detailed Listing F Flat ASCII file (pre-defined record format) Choose Type of Report: D// <RETURN>
--

- Type the corresponding letter of the type of report you want to print at the “Choose Type of Report:” prompt and press <RETURN>.

 - T Total Count Only.** Use this option to print only the total number of records that match the your selection criteria. If you select this report option, no further actions will be needed to generate the report.

 - S Sub-counts and Total Count.** Use this option to list the total number of matches and the subtotal of each different category of the sort variable selected (e.g., if you sort the report by sex, the number of visits for males and the number visits for females in the group will print, in addition to the total number of visits matching these criteria). If you select this report type, the Sort Item Selection Menu will be displayed (see Section 3.1.2.4, Selecting a Sort Category).

 - D Detailed Listing.** Use this option to create a report that prints only the data items you need sorted by the variable you select. A total visit count is also included. If you select this report type, the Print Item Selection Menu will be displayed (see Section 3.1.2.3, Selecting Print Items).

 - F Flat ASCII File.** Use this option to download data corresponding to the visits you have selected to a file for use in a spreadsheet or other software program. This file contains data for all the visits that match your selection criteria. The data downloaded is in a predefined file format that cannot be changed. If you select this option, a message will be displayed on the screen with the file name. Ask your Site Manager to retrieve the file. No additional steps are necessary to create the ASCII file.
-
- Type information as requested at each prompt and press <RETURN>.

 - After you enter the type of report information you want to print, type “Y” (Yes) or “N” (No) at the “Do you want a separate page for each Visit Date?” prompt and press <RETURN>.

 - Type “Y” (Yes) or “N” (No) at the “Would you like a custom title for this report?” prompt and press <RETURN>.

 - Type “Y” (Yes) or “N” (No) at the “Do you wish to Save this Search/Print/Sort logic for future use?” prompt and press <RETURN>.

 - The Report Summary Screen will be displayed.

 - Type the corresponding letter of the type of output you want at the “Do you wish to:” prompt and press <RETURN>.

- Type the print device at the “Device:” prompt and press <RETURN>.

The Mental Health and Social Services MHSS Record Listing Screen will print, as displayed below.

```

      MENTAL HEALTH AND SOCIAL SERVICES  MHSS RECORD LISTING

REPORT REQUESTED BY: DOUGLAS,BILL

The following report contains a MH/SS Record report based on the following criteria:

VISIT Selection Criteria

      Encounter Date range: JAN 01, 1997 to JAN 31, 1997
      Patient Sex: FEMALE
      Patient Age: 20-40
      Patient Community: SELLS

PRINT Field Selection
      Patient Name (15)
      Patient Chart # (8)
      Patient Age (4)
      Encounter Date (8)
      Location of Encounter (15)
      Activity Time (8)
      TOTAL column width: 68
      Records will be sorted by: Encounter Date

      ***** CONFIDENTIAL PATIENT INFORMATION *****
                    MH/SS ENCOUNTER LISTING                    Page 1
                    Record Dates: JAN 01, 1997 and JAN 31, 1997

PATIENT NAME           HRN   AGE  DATE  LOCATION OF ENC  ACT TIME
-----
THATCHER,LOUISE       SE100990  24  01/05/97  SELLS HOSPITAL/  30
STEWART,MARTHA        SE100675  18  01/08/97  SELLS HOSPITAL/  20
MILLER,SHANNON        SE102792  36  01/08/97  SELLS HOSPITAL/   5
MILLER,SHANNON        SE102792  36  01/10/97  SELLS HOSPITAL/  15
ADAMS,ROSE            SE306145  32  01/13/97  TUCSON ADMINIST  30
ORSO,LUCILLE          SE308966  39  01/18/97  SELLS HOSPITAL/  30

Total Records: 6
Total Patients: 6
RUN TIME (H.M.S): 0.0.4
End of report. HIT RETURN:

```

Mental Health and Social Services MHSS Record Listing Screen

3.2.3 Potentially Billable MH/SS Visits

- To print a list of potentially billable MH/SS visits for all patients registered at a facility, type "BILL" at the "Select MH/SS Record/Encounter Reports Option:" prompt and press <RETURN>.

The following screen will be displayed.

<p>This Option prints who are a list of Potentially Billable Contacts for all patients registered at the Facility that you select who have been seen by Mental Health and Social Services. The user will select which third party coverage type that they are interested in seeing billable visits for. This report displays visits during a period when this patient had third party coverage, but does not consider the diagnostic category, which may be excluded by some types of coverage.</p> <p>Run the report for Patients registered at which Facility: Aberdeen</p> <table><tr><td>1</td><td>ABERDEEN</td><td>ABERDEEN URBAN SOUTH DAKOTA</td></tr><tr><td></td><td></td><td>URBAN 82</td></tr><tr><td>2</td><td>ABERDEEN ADMINISTRATION</td><td>ABERDEEN NON SERVICE UNIT 00</td></tr><tr><td>3</td><td>ABERDEEN AO</td><td>ABERDEEN NON SERVICE UNIT 90</td></tr></table> <p>CHOOSE 1-3: 1</p> <p>Starting Visit Date for Billable Visits: April 24, 1997 (APR 24, 1997)</p> <p>Ending Visit Date for Billable Visits: June 23, 1997 (JUN 23, 1997)</p> <p>Select one of the following:</p> <table><tr><td>1</td><td>Commissioned Officers/Dependents</td></tr><tr><td>2</td><td>Medicare Part A</td></tr><tr><td>3</td><td>Medicare Part B</td></tr><tr><td>4</td><td>Medicaid</td></tr><tr><td>5</td><td>Private Insurance</td></tr><tr><td>6</td><td>Non-Indians</td></tr></table> <p>Select Third Party Coverage:</p>	1	ABERDEEN	ABERDEEN URBAN SOUTH DAKOTA			URBAN 82	2	ABERDEEN ADMINISTRATION	ABERDEEN NON SERVICE UNIT 00	3	ABERDEEN AO	ABERDEEN NON SERVICE UNIT 90	1	Commissioned Officers/Dependents	2	Medicare Part A	3	Medicare Part B	4	Medicaid	5	Private Insurance	6	Non-Indians
1	ABERDEEN	ABERDEEN URBAN SOUTH DAKOTA																						
		URBAN 82																						
2	ABERDEEN ADMINISTRATION	ABERDEEN NON SERVICE UNIT 00																						
3	ABERDEEN AO	ABERDEEN NON SERVICE UNIT 90																						
1	Commissioned Officers/Dependents																							
2	Medicare Part A																							
3	Medicare Part B																							
4	Medicaid																							
5	Private Insurance																							
6	Non-Indians																							

- Type the facility for which you want to run a report at the "Run the report for Patients registered at which Facility:" prompt and press <RETURN>.
- Type the date you want to begin printing the report at the "Starting Visit Date for Billable Visits:" prompt and press <RETURN>.
- Type the date you want to stop printing the report at the "Ending Visit Date for Billable Visits:" prompt and press <RETURN>.
- Type the corresponding number of the type of third party billing coverage you want in the report at the "Select Third Party Coverage:" prompt and press <RETURN>.

The Potentially Billable Mental Health/Social Services Visits for the type of coverage you selected will print, as displayed below. This report will display visits during a specified time period when the patient had third-party coverage but will not consider the diagnostic category for the visit, which may be excluded by some types of coverage.

***** CONFIDENTIAL PATIENT INFORMATION *****		
SELLS HOSPITAL/CLINIC		Page 1
POTENTIALLY BILLABLE MENTAL HEALTH/SOCIAL SERVICES VISITS FOR		
Private Insurance		
Visit Dates: JAN 1,1997 and JAN 31,1997		
HRCN Patient Name	Date of Birth	SSN

45676 HALL,MONTY A	MAR 03, 1942	567552332
INSURER: MET LIFE		
POLICY #: 010101010	COVERAGE TYPE:	
INSURED: HALL,MONTY A	REL: SELF	
ELIG BEG DATE: JAN 01, 1995	ELIG END DATE:	
DATE CONTACT PD PRV ACT MIN DSM/PC MHSS PROVIDER NARRATIVE ICDDX		

01/08/97 OUTPATI 53 MJS 12 20 311. DEPRESSIVE DISORDER NOS 311.		
01/23/97 OUTPATI 53 SAD 12 30 311. DEPRESSIVE DISORDER NOS 311.		
HRCN Patient Name	Date of Birth	SSN

35000 SMITH,JAMIE LYNN	SEP 01, 1958	442446454
INSURER: BC/BS OF ARIZONA INC		
POLICY #: A-78577	COVERAGE TYPE:	
INSURED: SMITH,JAMIE LYNN	REL: SELF	
ELIG BEG DATE: JAN 01, 1989	ELIG END DATE:	
DATE CONTACT PD PRV ACT MIN DSM/PC MHSS PROVIDER NARRATIVE ICD DX		

01/06/97 OUTPATI 19 BD 11 20 311. DEPRESSIVE DISORDER NOS 311.		
01/27/97 INPATIE 06 LAB 11 30 45.2 ABUSIVE V15.49		
RUN TIME (H.M.S): 0.0.12		
End of report.		

Potentially Billable Mental Health/Social Services Visits

3.3 Workload/Activity Reports

The Workload/Activity Reports Menu presents options to generate reports related specifically to the activities of Mental Health/Social Service providers. Included are options for generating reports that categorize and tabulate activity times, frequency of activities, and primary problems requiring Mental Health/Social Service care.

- **To view the Activity Workload Reports Menu, type “WL” at the “Select Reports Menu Option:” prompt and press <RETURN>.**

The Activity Workload Reports Menu will be displayed.

```
*****  
**      IHS Mental Health/Social Services System      **  
**              Activity Workload Reports              **  
*****  
                          Version 2.0  
  
                ALBUQUERQUE HOSPITAL  
  
GRS1   Activity Report (GARS #1)  
GRS2   Activity Report by Primary Problem (GARS #2)  
ACT    Activity Record Counts  
PROG   Program Activity Time Reports  
FACT   Frequency of Activities  
FCAT   Frequency of Activities by Category  
  
Select Workload/Activity Reports Option:
```

Activity Workload Reports Menu

3.3.1 Activity Report (GARS #1)

- To tally activities by service unit, facility, and provider, type “GRS1” at the “Select MH/SS Record/Encounter Reports Option:” prompt and press <RETURN>.

The Activity Report Screen will be displayed.

```
***** ACTIVITY REPORT *****

This report will tally activities by service unit, facility, and by provider. This report was
patterned after GARS Report #1.

Enter beginning Encounter Date: April 24, 1997 (APR 24, 1997)

Enter ending Encounter Date: (4/24/97-6/23/97): APR 24, 1997// T (JUN 23, 1997)

Select one of the following:
  M   MENTAL HEALTH
  S   SOCIAL SERVICES
  O   OTHER
  A   ALL

Run Report for which Program: M// ENTAL HEALTH

Select one of the following:
  1   ONE PROVIDER
  2   ALL PROVIDERS

Run Report for: 1// 1 ONE PROVIDER
Select NEW PERSON NAME: ADAM,ADAM

Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>
```

Activity Report Screen

- Type the date you want to begin tallying activities at the “Enter beginning Encounter Date:” prompt and press <RETURN>.
- Type the date you want to stop tallying activities at the “Enter ending Encounter Date:” prompt and press <RETURN>.
- Type the corresponding letter of the type of activity you want to include in the report at the “Run Report for which Program:” prompt and press <RETURN>.

- Type the corresponding number of the type of provider activity you want to include in the report at the "Run Report for:" prompt and press <RETURN>. If you select "1" (One Provider), type the name of the provider at the "Select New Person Name:" prompt and press <RETURN>.
- Type the corresponding letter of the type of output you want at the "Do you wish to:" prompt and press <RETURN>.
- Type the print device at the "Device:" prompt and press <RETURN>.

The Activity Report for the activity you want to view will print, as displayed below.

***** CONFIDENTIAL PATIENT INFORMATION ***** JAN 31, 1997 Page 1			
ACTIVITY REPORT FOR MENTAL HEALTH PROGRAM			
RECORD DATES: JAN 01, 1997 TO JAN 31, 1997			
	# RECS	ACT TIME	# PATS

AREA: TUCSON			
SERVICE UNIT: SELLS			
FACILITY: SELLS HOSPITAL/CLINIC			
PROVIDER: CISCO,SID (MENTAL HEALTH)			
11-SCREENING-PATIENT PRESENT	8	150	6
13-INDIVIDUAL TREATMENT/COUNS	1	20	1
71-TRAVEL RELATED TO PATIENT	1	30	
	=====	=====	=====
PROVIDER TOTAL:	10	200	7
PROVIDER: DOUGLAS,BILL (MENTAL HEALTH)			
11-SCREENING-PATIENT PRESENT	76	1570	35
12-ASSESSMENT/EVALUATION-PATI	1	30	1
13-INDIVIDUAL TREATMENT/COUNS	14	660	12
20-FAMILY FACILITATION-PATIEN	1	20	
32-CLINICAL SUPERVISION-PATIE	1	20	
51-COMMITTEE WORK	1	240	
63-PROGRAM CONSULTATION	1	120	
71-TRAVEL RELATED TO PATIENT	1	20	
72-TRAVEL NOT RELATED TO PATI	4	70	
	=====	=====	=====
PROVIDER TOTAL:	100	2750	48
	=====	=====	=====
FACILITY TOTAL:	110	3950	55
	=====	=====	=====
SU TOTAL:	110	3950	55
	=====	=====	=====
AREA TOTAL:	110	3950	55
RUN TIME (H.M.S): 0.0.1			

Activity Report Screen

3.3.2 Activity Report by Primary Problem (GARS #2)

- To tally primary problems by service unit, facility, provider, and activity, type “GRS2” at the “Select MH/SS Record/Encounter Reports Option:” prompt and press <RETURN>.

The Activity By Primary Purpose Report Screen will be displayed.

```
***** ACTIVITY BY PRIMARY PUPOSE REPORT *****

This report will tally PRIMARY problems by service unit, facility, and by provider and
activity. This report was patterned after GARS Report #2.

This report requires 132 column print capability! Contact your site manager to determine
which printer to use.

Enter beginning Encounter Date: April 24, 1997 (APR 24, 1997)

Enter ending Encounter Date: (4/24/97-6/23/97): APR 24, 1997// June 23, 1997(JUN 23,
1997)

Select one of the following:
M    MENTAL HEALTH
S    SOCIAL SERVICES
O    OTHER
A    ALL

Run Report for which Program: M// ENTAL HEALTH

Select one of the following:
1    ONE PROVIDER
2    ALL PROVIDERS

Run Report for: 1// ONE PROVIDER
Enter PROVIDER: ADAM,ADAM

Select one of the following:
P    PRINT Output
B    BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>
```

Activity By Primary Purpose Report Screen

- Type the date you want to begin tallying primary problems at the “Enter beginning Encounter Date:” prompt and press <RETURN>.

- Type the date you want to stop tallying primary problems at the "Enter ending Encounter Date:" prompt and press <RETURN>.
- Type the corresponding letter of the type of activity you want to include in the report at the "Run Report for which Program:" prompt and press <RETURN>.
- Type the corresponding number of the type of provider activity you want to include in the report at the "Run Report for:" prompt and press <RETURN>. If you select "1" (One Provider), type the name of the provider at the "Select New Person Name:" prompt and press <RETURN>.
- Type the corresponding letter of the type of output you want at the "Do you wish to:" prompt and press <RETURN>.

- Type the print device at the “Device:” prompt and press <RETURN>.

The Activity Report By Primary Purpose Screen for the activity you selected will print, as displayed below.

JAN 31, 1997		Page 1		
ACTIVITY REPORT BY PRIMARY PURPOSE FOR MENTAL HEALTH PROGRAM RECORD DATES: JAN 01, 1997 TO JAN 31, 1997				
	#RECS	ACT TIME	# PATS	

AREA: TUCSON				
SERVICE UNIT: SELLS				
FACILITY: SELLS HOSPITAL/CLINIC				
PROVIDER: NYE,PATRICIA (MENTAL HEALTH)				
ACTIVITY: 16-MEDICATION/MEDICATION MON				
295.24-SCHIZOPHRENIA,CATATONIC,CHRONIC W	1	45	1	
	=====	=====	=====	
ACTIVITY TOTAL:	1	45	1	
ACTIVITY: 64-STAFF CONSULTATION				
97-ADMINISTRATION				
	=====	=====	=====	
ACTIVITY TOTAL:	1	30	0	
	=====	=====	=====	
PROVIDER TOTAL:	2	75	1	
	=====	=====	=====	
FACILITY TOTAL:	2	75	1	
	=====	=====	=====	
SU TOTAL:	2	75	1	
	=====	=====	=====	
AREA TOTAL:	2	75	1	
RUN TIME (H.M.S): 0.0.0				
End of report.				

Activity Report By Primary Purpose Screen

3.3.3 Activity Record Counts

- To tally activity records for a category and a specified date range (and to select specific records to include in the tabulation), type "ACT" at the "Select MH/SS Record/Encounter Reports Option:" prompt and press <RETURN>.

The Activity Record Counts Screen will be displayed.

***** ACTIVITY RECORD COUNTS*****

This report will generate a count of activity records for an item you select for a date range that you specify.

You will be given the opportunity to select which contacts will be included in the tabulation. For example, you can choose to tally activity time by Problem Code for only those with a discipline of Psychiatrist.

- 1). Provider of Service
- 2). Appointment/Walk-In
- 3). Interpreter Utilized
- 4). Discipline of Provider
- 5). Program Type
- 6). Date of Visit
- 7). POV/Problem (Problem Code)
- 8). Problem/POV (Problem Category)
- 9). Problem/POV
- 10). Location of Service
- 11). Service Unit of Service
- 12). Type of Contact of Visit
- 13). Activity Code
- 14). Activity Category
- 15). Community of Service

Choose an item for calculating activity time and record counts: (1-15):1

Enter beginning Contact Date for Search: April 24, 1997 (APR 24, 1997)

Enter ending Contact Date for Search: (4/24/97 - 6/23/97): APR 24, 1997// T (JUN 23, 1997)

Activity Record Counts Screen

- Type the item you want to use to calculate activity time and record counts at the "Choose an item for calculating activity time and record counts:" prompt and press <RETURN>.
- Type the date you want to begin tallying activity records for a category at the "Enter beginning Contact Date for Search:" prompt and press <RETURN>.

- Type the date you want to stop tallying activity records for a category at the “Enter ending Contact Date for Search:” prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex).

- Type “S” at the “Select Action:” prompt and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.
- Type “Q” at the “Select Action:” prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed.

```
Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>
```

- Type the corresponding letter of the type of output you want at the “Do you wish to:” prompt and press <RETURN>.

- Type the print device at the "Device:" prompt and press <RETURN>.

A Mental Health/Social Services Record Listing Screen will print, as displayed below.

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING				
REPORT REQUESTED BY: ROANHORSE,DINA				
The following visit listing contains MH/SS records selected based on the following criteria:				
RECORD SELECTION CRITERIA				
Encounter Date range: JAN 01, 1997 to JAN 31, 1997				
Patient Age: 20-50				
Patient Community: SELLS				
Report Type: RECORD COUNTS/ACTIVITY TIME TOTALS				
JAN 31, 1997 Page 1				
RECORD DATES: JAN 01, 1997 TO JAN 31, 1997				
NUMBER OF ACTIVITY RECORDS BY PROBLEM CATEGORY				
CATEGORY NARRATIVE	CATEGORY CODE	# RECS	# PATS	ACTIVITY TIME
ABUSE	3	11	8	4.9
ADMINISTRATIVE PROBLEM	11	4	2	0.5
FAMILY LIFE PROBLEMS	5	5	4	1.9
MEDICAL/SOCIAL PROBLEMS	1	1	1	0.9
NO PROBLEMS/POVS ENTERED	---	1	1	0.3
PREGNANCY/CHILDBIRTH PROB	6	1	1	0.3
PSYCHOSOCIAL PROBLEMS	2	45	24	17.1
Totals:		68	41	25.8
RUN TIME (H.M.S): 0.0.3				
End of report. HIT RETURN:				

Mental Health/Social Services Record Listing Screen

3.3.4 Program Activity Time Reports

- To generate a count of activity records, total activity time, and number of patient contacts by program and by selected item, type “PROG” at the “Select MH/SS Record/Encounter Reports Option:” prompt and press <RETURN>.

The Program Activity Time, Patient, and Record Counts Screen will be displayed.

* PROGRAM ACTIVITY TIME, PATIENT AND RECORD COUNTS *

This report will generate a count of activity records, total activity time and number of patient contacts by Program and by an item you select for a date range that you specify. You will be given the opportunity to select which contacts will be included in the report. For example, you may wish to only report on those records on which the type of contact was Field.

NOTE: If you choose to report on Problems, ONLY THE PRIMARY PROBLEM is included.

- 1). Provider of Service
- 2). Discipline of Provider
- 3). Program Type
- 4). Date of Visit
- 5). POV/Problem (Problem Code)
- 6). Problem/POV (Problem Category)
- 7). Problem/POV
- 8). Location of Service
- 9). Service Unit of Service
- 10). Type of Contact of Visit
- 11). Activity Code
- 12). Activity Category
- 13). Community of Service

Choose an item for calculating program activity time/record counts: (1-13): 1

Enter beginning Contact Date for Search: April 24, 1997 (APR 24, 1997)

Enter ending Contact Date for Search: (4/24/97 - 6/24/97): APR 24, 1997// June 24, 1997

Program Activity Time, Patient, and Record Counts Screen

- Type the item you want to use to calculate activity time and record counts at the “Choose an item for calculating program activity time/record counts:” prompt and press <RETURN>.
- Type the date you want to begin calculating activity time and record counts for a category at the “Enter beginning Contact Date for Search:” prompt and press <RETURN>.

- Type the date you want to stop calculating activity time and record counts for a category at the "Enter ending Contact Date for Search:" prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex).

- Type "S" at the "Select Action:" prompt and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.
- Type "Q" at the "Select Action:" prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed.

```
Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>
```

- Type the corresponding letter of the type of output you want at the "Do you wish to:" prompt and press <RETURN>.

- Type the print device at the "Device:" prompt and press <RETURN>.

A Mental Health/Social Services Record Listing Screen will print, as displayed below. A cover page that indicates the record selection criteria is displayed with every report. The report shown here tabulates records, patients, and activity times by location of service.

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING REPORT REQUESTED BY: CISCO,SID									
The following visit listing contains MH/SS records selected based on the following criteria:									
RECORD SELECTION CRITERIA									
Encounter Date range: JAN 01, 1997 to JAN 31, 1997									
Patient Age: 20-45									
Report Type: PROGRAM ACTIVITY REPORT									
MENTAL HEALTH AND SOCIAL SERVICE					JAN 31, 1997 Page 1				
ACTIVITY TIME, PATIENT AND RECORD COUNT REPORT BY PROGRAM AND LOCATION OF SERVICE									
RECORD DATES: JAN 01, 1997 TO JAN 31, 1997									
SOCIAL SERVICES AND MENTAL HEALTH COMB			SOCIAL SERVICE			MENTAL HEALTH			
NO. OF LOCATION RECORDS ACTIVITYTIME	NO. OF PATIENTS	TOTAL ACTIV TIME	NO. OF RECORDS	NO. OF PATIENTS	TOTAL ACTIV TIME	NO. OF RECORDS	NO. OF PATIENTS	TOTAL	

ALBUQ	2	2	1.5	1	1	0.5	1	1	1.0
CHINLE HOS	4	8	4.7	2	4	2.8	2	4	1.9
MOB UNIT	8	7	5.7	2	2	0.8	6	5	4.9
SAN XAVIER	9	6	4.8	4	4	2.0	5	2	2.8
SANTA FE	1	1	1.0	1	1	1.0	.	.	.
SANTA ROS	2	1	0.8	.	.	.	2	1	0.8
SELLS	4	12	5.2	3	2	1.2	1	10	4.0
TOTALS:	30	37	23.7	13	14	8.3	17	23	15.4
**** Patient Count TOTAL is not an unduplicated count.									
RUN TIME (H.M.S): 0.0.2									
End of report. HIT RETURN:									

Mental Health/Social Services Record Listing Screen

3.3.5 Frequency of Activities

- To generate a list of the top activity codes for selected visits, type "FACT" at the "Select MH/SS Record/Encounter Reports Option:" prompt and press <RETURN>.

The Frequency of Activity Code Report Screen will be displayed. You may specify the number of top activity codes that display in the report (e.g., top 10 or top 20).

<p>Frequency of Activity Code Report.</p> <p>This report will generate a list of the top N Activity Code for contacts that you select.</p> <p>Enter beginning Contact Date for Search: April 24, 1997 (APR 24, 1997)</p> <p>Enter ending Contact Date for Search: (4/24/97 - 6/24/97): APR 24, 1997// June 24, 1997 (JUN 24, 1997)</p>
--

Frequency of Activity Code Report

- Type the date you want to begin generating a list of top activity codes for selected visits at the "Enter beginning Contact Date for Search:" prompt and press <RETURN>.
- Type the date you want to stop generating a list of top activity codes for selected visits at the "Enter ending Contact Date for Search:" prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex).

- Type "S" at the "Select Action:" prompt and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.

- Type “Q” at the “Select Action:” prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed. The screen below displays the List of Items with Counts option.

```
Select one of the following:
  L   List of items with Counts
  B   Bar Chart (132 col)

Select Type of Report: L// <RETURN>

Select Type of Report: L// ist of items with Counts
How many entries do you want in the list: (5-100): 10// <RETURN>

Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// <RETURN>
```

- Type the corresponding letter of the type of report you want to print at the “Select Type of Report:” prompt and press <RETURN>.
- Type the number of entries you want to print in the list at the “How many entries do you want in the list:” prompt and press <RETURN>.
- Type the corresponding letter of the type of output you want at the “Do you wish to:” prompt and press <RETURN>.

3.3.6 Frequency of Activities by Category

- To generate a list of activities in categories, type “FCAT” at the “Select MH/SS Record/Encounter Reports Option:” prompt and press <RETURN>.

The Frequency of Activity Category Report Screen will be displayed. The Frequency of Activities by Category Report is almost identical to the Frequency of Activities Report, except that it reports the activities in categories.

Frequency of Activity Category Report.

This report will generate a list of the top N Activity Category for contacts that you select.

Enter beginning Contact Date for Search: April 24,1997 (APR 24, 1997)

Enter ending Contact Date for Search: (4/24/97 - 6/24/97): APR 24, 1997// T (JUN 24, 1997)

Frequency of Activity Category Report

- Type the date you want to begin generating a list of activities in categories at the “Enter beginning Contact Date for Search:” prompt and press <RETURN>.
- Type the date you want to stop generating a list of activities in categories at the “Enter ending Contact Date for Search:” prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex).

- Type “S” at the “Select Action:” prompt and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.

- Type "Q" at the "Select Action:" prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed. The screen below displays the List of Items with Counts option.

```
Select one of the following:
  L   List of items with Counts
  B   Bar Chart (132 col)

Select Type of Report: L// <RETURN>

Select Type of Report: L// ist of items with Counts
How many entries do you want in the list: (5-100): 10// <RETURN>

Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to: P// <RETURN>
```

- Type the corresponding letter of the type of report you want to print at the "Select Type of Report:" prompt and press <RETURN>.
- Type the number of entries you want to print in the list at the "How many entries do you want in the list:" prompt and press <RETURN>.
- Type the corresponding letter of the type of output you want at the "Do you wish to:" prompt and press <RETURN>.

- Type the print device at the “Device:” prompt and press <RETURN>.

The Mental Health/Social Services Record Listing Report will print, as displayed below.

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING

REPORT REQUESTED BY: GILL,SUSAN

The following contact listing contains MH/SS contacts selected based on the following criteria:

RECORD SELECTION CRITERIA

Encounter Date range: APR 24, 1997 to JUN 24, 1997

Patient Sex: FEMALE

Report Type: FREQUENCY REPORT (TOP TEN)

Press return to continue....:

JUN 24, 1997 Page 1
ALBUQUERQUE HOSPITAL

TOP 10 Activity Category's.
DATES: APR 24, 1997 TO JUN 24, 1997

No.	ACTIVITY CATEGORY	CATEGORY CODE	# RECS	ACT TIME (MINS)
1.	SUPPORT SERVICES	S	4	6
2.	PATIENT SERVICES	P	2	33

RUN TIME (H.M.S): 0.0.0
End of report. PRESS RETURN:

Mental Health/Social Services Record Listing Report

3.4 Problem Specific Reports

The Problem Specific report options concern particular problem areas of interest to IHS Mental Health/Social Service providers. In addition, reports that tabulate problems by frequency are provided.

- To view the Problem Specific Reports Menu, type “PROB” at the “Select Reports Menu Option:” prompt and press <RETURN>.

The Problem Specific Reports Menu will be displayed.

```
*****  
**      IHS Mental Health/Social Services System      **  
**              Problem Specific Reports              **  
*****  
                          Version 2.0  
  
                        ALBUQUERQUE HOSPITAL  
  
SUIC      Suicide Report (Age&Sex)  
ABU       Abuse Report (Age&Sex)  
FDSM      Frequency of Problems  
FPRB      Frequency of Problems (Problem Code Groupings)  
FPRC      Frequency of Problems by Problem Category  
  
Select Problem Specific Reports Option:
```

Problem Specific Reports Menu

3.4.1 Suicide Report (Age and Sex)

- To tabulate a suicide report using the age and sex of individual patients, type “SUIC” at the “Select Problem Specific Reports Option:” prompt and press <RETURN>.

The Suicide Report Screen will be displayed.

SUICIDE REPORT

This report will present, by age and sex, the number of individual patients who were seen for the following Problem Codes:

- 39 - SUICIDE (IDEATION)
- 40 - SUICIDE (ATTEMPT/GESTURE)
- 41 - SUICIDE (COMPLETED)

Please enter the date range during which the patient should have been seen with one of these problems.

Enter Beginning Visit Date: April 24, 1997 (APR 24, 1997)

Enter Ending Visit Date: (4/24/97 - 6/24/97): APR 24, 1997// T (JUN 24, 1997)

The Age Groups to be used are currently defined as:

- 0 - 0
- 1 - 4
- 5 - 14
- 15 - 19
- 20 - 24
- 25 - 44
- 45 - 64
- 65 - 125

Do you wish to modify these age groups? N NO

This report should be printed on 132 column paper or on a printer with condensed print.

Select one of the following:

- P PRINT Output
- B BROWSE Output on Screen

Do you wish to: P// <RETURN>

DEVICE: HOME// <RETURN>

Suicide Report Screen

- Type the date you want to begin tabulating the Suicide Report at the "Enter Beginning Visit Date:" prompt and press <RETURN>.
- Type the date you want to stop tabulating the Suicide Report at the "Enter Ending Visit Date:" prompt and press <RETURN>.
- Type "Y" (Yes) or "N" (No) at the "Do you wish to modify these age groups?" prompt and press <RETURN>. If you type "Y", enter information as requested at the prompts that follow.
- Type the corresponding letter of the type of output you want at the "Do you wish to:" prompt and press <RETURN>.
- Type the print device at the "Device:" prompt and press <RETURN>.

The Mental Health/Social Services Record Suicide Report By Age and Sex will print, as displayed below.

MENTAL HEALTH AND SOCIAL SERVICES JAN 27, 1997 Page 1							
SUICIDE REPORT BY AGE AND SEX							
VISIT DATES: JAN 01, 1986 TO DEC 31, 1996							
SEX: BOTH							
PROB CODE NARRATIVE	0-14	15-19	20-29	30-39	40-49	50-100	TOTAL

39 - SUICIDE (IDEATION)	.	.	1	1	1	7	10
40 - SUICIDE (ATTEMPT/GESTURE)	.	.	3	.	1	5	9
41 - SUICIDE (COMPLETED)	1	.	.	.	.	.	1
TOTAL:	1	.	4	1	2	12	20
SEX: FEMALE							
PROB CODE NARRATIVE	0-14	15-19	20-29	30-39	40-49	50-100	TOTAL

39 - SUICIDE (IDEATION)	.	.	.	.	.	5	5
40 - SUICIDE (ATTEMPT/GESTURE)	.	.	2	.	1	5	8
41 - SUICIDE (COMPLETED)	1	.	.	.	.	.	1
TOTAL:	1	.	2	.	1	10	14
SEX: MALE							
PROB CODE NARRATIVE	0-14	15-19	20-29	30-39	40-49	50-100	TOTAL

39 - SUICIDE (IDEATION)	.	.	1	1	1	2	5
40 - SUICIDE (ATTEMPT/GESTURE)	.	.	1	.	.	.	1
41 - SUICIDE (COMPLETED)	.	.	.	.	.	.	.
TOTAL:	.	.	2	1	1	2	6
RUN TIME (H.M.S): 0.0.0							
End of report. HIT RETURN:							

Mental Health/Social Services Record Suicide Report By Age and Sex

3.4.2 Abuse Report (Age and Sex)

- To count the number of patients seen in abuse cases by age and sex, type “ABU” at the “Select Problem Specific Reports Option:” prompt and press <RETURN>.

The Abuse Report Screen will be displayed. If there have been no recorded visits for a particular problem code, the code will not be displayed in the report.

ABUSE REPORT

This report will present, by age and sex, the number of individual patients who were seen for the following Problem Codes:

- 42 - CHILD ABUSE (SUSPECTED),UNSPECIFIED
- 42.1 - CHILD ABUSE (SUSPECTED), PHYSICAL
- 42.2 - CHILD ABUSE (SUSPECTED),EMOTIONAL
- 42.3 - CHILD ABUSE (SUSPECTED),SEXUAL
- 43 - PARTNER ABUSE (SUSPECTED),UNSPECIFIED
- 43.1 - PARTNER ABUSE (SUSPECTED),PHYSICAL
- 43.2 - PARTNER ABUSE (SUSPECTED),EMOTIONAL
- 43.3 - PARTNER ABUSE (SUSPECTED), SEXUAL
- 44 - ADULT ABUSE (SUSPECTED),UNSPECIFIED
- 44.1 - ADULT ABUSE (SUSPECTED),PHYSICAL
- 44.2 - ADULT ABUSE (SUSPECTED),EMOTIONAL
- 44.3 - ADULT ABUSE (SUSPECTED),SEXUAL
- 45 - ABUSIVE BEHAVIOR (ALLEGED),UNSPECIFIED
- 45.1 - ABUSIVE BEHAVIOR (ALLEGED),PHYSICAL
- 45.2 - ABUSIVE BEHAVIOR (ALLEGED), EMOTIONAL
- 45.3 - ABUSIVE BEHAVIOR (ALLEGED),SEXUAL (EXCLUDES RAPE)
- 995.5 - ABUSE/NEGLECT OF CHILD (VICTIM)
- 995.53- SEXUAL ABUSE OF CHILD (VICTIM)
- 995.54 - PHYSICAL ABUSE OF CHILD (VICTIM)
- 995.81 - ABUSE/NEGLECT OF ADULT (VICTIM)

Please enter the date range during which the patient should have been seen with one of these problems.

Enter Beginning Visit Date: JANUARY 1, 1996 (JAN 01, 1996)

Enter Ending Visit Date: (1/1/96 - 6/25/97): JAN 01, 1996// T (JUN 25, 1997)

The Age Groups to be used are currently defined as:

- 0 - 0
- 1 - 4
- 5 - 14
- 15 - 19
- 20 - 24
- 25 - 44
- 45 - 64
- 65 - 125

Do you wish to modify these age groups? N NO

This report should be printed on 132 column paper or on a printer with condensed print.

```
Select one of the following:
P      PRINT Output
B      BROWSE Output on Screen

Do you wish to : P// <RETURN>
DEVICE: HOME// <RETURN>
```

Abuse Report Screen

- Type the date you want to begin tabulating the Abuse Report at the “Enter Beginning Visit Date:” prompt and press <RETURN>.
- Type the date you want to stop tabulating the Abuse Report at the “Enter Ending Visit Date:” prompt and press <RETURN>.
- Type “Y” (Yes) or “N” (No) at the “Do you wish to modify these age groups?” prompt and press <RETURN>. If you type “Y”, enter information as requested at the prompts that follow.
- Type the corresponding letter of the type of output you want at the “Do you wish to:” prompt and press <RETURN>.
- Type the print device at the “Device:” prompt and press <RETURN>.

The Mental Health/Social Services Abuse Report By Age and Sex will print, as displayed on the next page.

MENTAL HEALTH AND SOCIAL SERVICES								JAN 27, 1997	Page1
ABUSE REPORT BY AGE AND SEX									
VISIT DATES: JAN 01, 1996 TO DEC 31, 1996									
SEX: BOTH									
PROB CODE NARRATIVE	0-9	10-19	20-29	30-39	40-49	50-100	TOTAL		
42.1 - CHILD ABUSE (SUSPECTED)	1	1	1	2	1	.	6		
42.2 - CHILD ABUSE (SUSPECTED)	.	.	.	.	1	.	1		
43.3 - PARTNER ABUSE (SUSPECTE	.	1	.	.	1	.	2		
44 - ADULT ABUSE (SUSPECTED),U	.	.	.	1	.	1	2		
44.1 - ADULT ABUSE (SUSPECTED)	.	1	.	.	.	1	2		
45 - ABUSIVE BEHAVIOR (ALLEGED	.	1	2	3	1	3	10		
45.2 - ABUSIVE BEHAVIOR (ALLEG	.	.	.	.	.	1	1		
45.3 - ABUSIVE BEHAVIOR (ALLEG	.	.	.	.	1	.	1		
995.81 - ABUSE/NEGLECT OF ADUL	.	.	.	.	1	1	2		
TOTAL:	1	4	3	6	6	7	27		
SEX: FEMALE									
PROB CODE NARRATIVE	0-9	10-19	20-29	30-39	40-49	50-100	TOTAL		
42.1 - CHILD ABUSE (SUSPECTED)	.	.	1	2	.	3	6		
42.3 - CHILD ABUSE (SUSPECTED)	.	.	.	.	1	.	1		
44 - ADULT ABUSE (SUSPECTED),U	.	.	.	.	1	1	2		
44.1 - ADULT ABUSE (SUSPECTED)	.	1	.	.	.	.	1		
45 - ABUSIVE BEHAVIOR (ALLEGED	6	.	1	.	2	1	2		
45.2 - ABUSIVE BEHAVIOR (ALLEG	.	.	.	.	.	1	1		
45.3 - ABUSIVE BEHAVIOR (ALLEG	.	.	.	.	1	.	1		
995.81 - ABUSE/NEGLECT OF ADUL	.	.	.	.	1	1	2		
TOTAL:	.	2	1	4	4	5	16		
SEX: MALE									
PROB CODE NARRATIVE	0-9	10-19	20-29	30-39	40-49	50-100	TOTAL		
42.1 - CHILD ABUSE (SUSPECTED)	1	1	.	.	1	.	3		
43.3 - PARTNER ABUSE (SUSPECTE	.	1	.	.	1	.	2		
44 - ADULT ABUSE (SUSPECTED),U	.	.	.	1	.	.	1		
44.1 -ADULT ABUSE (SUSPECTED)	.	.	.	.	.	1	1		
45 - ABUSIVE BEHAVIOR (ALLEGED	4	.	.	2	1	.	1		
TOTAL:	1	2	2	2	2	2	11		
RUN TIME (H.M.S): 0.0.0									
End of report. HIT RETURN:									

Mental Health/Social Services Abuse Report By Age and Sex

3.4.3 Frequency of Problems

- To generate a list of the top primary problems/POVs for selected contacts, type "FDSM" at the "Select Problem Specific Reports Option:" prompt and press <RETURN>.

The Frequency of Problem/POV Report will be displayed.

Frequency of Problem/POV Report. This report will generate a list of the top N Problem/POV for contacts that you select. Enter beginning Contact Date for Search: January 1, 1996 (JAN 01, 1996) Enter ending Contact Date for Search: (1/1/96 - 6/25/97): JAN 01, 1996// T (JUN 25, 1997)

- Type the date you want to begin tabulating the Frequency of Problem/POV Report at the "Enter beginning Contact Date for Search:" prompt and press <RETURN>.
- Type the date you want to stop tabulating the Abuse Report at the "Enter ending Contact Date for Search:" prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex).

- Type "S" at the "Select Action:" prompt and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.

- Type “Q” at the “Select Action:” prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed.

```
Select one of the following:
  P   PRIMARY POV Only
  S   PRIMARY and SECONDARY POV's

Include which POV's: P// RIMARY POV Only

Select one of the following:
  L   List of items with Counts
  B   Bar Chart (132 col)

Select Type of Report: L// ist of items with Counts
How many entries do you want in the list: (5-100): 10//

Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>
```

- Type the corresponding letter of the type of POV you want to print at the “Include which POV's:” prompt and press <RETURN>.
- Type the corresponding letter of the type of report you want to print at the “Select Type of Report:” prompt and press <RETURN>.
- Type the number of entries you want to print in the list at the “How many entries do you want in the list:” prompt and press <RETURN>.
- Type the corresponding letter of the type of output you want at the “Do you wish to:” prompt and press <RETURN>.

- Type the print device at the "Device:" prompt and press <RETURN>.

The Frequency Report will print, as displayed below.

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING				
REPORT REQUESTED BY: GILL,SUSAN				
The following contact listing contains MH/SS contacts selected based on the following criteria:				
RECORD SELECTION CRITERIA				
Encounter Date range: JAN 01, 1996 to JUN 25, 1997				
Patient Sex: FEMALE				
Report Type: FREQUENCY REPORT (TOP TEN)				
TOP 10 Problem/POV's.				
PRIMARY POV Only				
DATES: JAN 01, 1996 TO JUN 25, 1997				
No.	PROB DSM/CODE NARRATIVE	CODE	# RECS	ACT TIME (MINS)
1.	ABUSIVE BEHAVIOR (ALLEGED), EM	45.2	1	3
2.	ADULT/CHILD RELATIONSHIP	53	1	30
3.	DRUG-INDUCED PSYCHOTIC DISOR	292.11	1	1
4.	SLEEP DISORDER	22	1	3
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS RETURN: <RETURN>				

Frequency Report

3.4.4 Frequency of Problems (Problem Code Groupings)

- To list and count the top primary POVs/problems (problem code groupings) for selected visits, type “FPRB” at the “Select Problem Specific Reports Option:” prompt and press <RETURN>.

NOTE: This report is similar to the Frequency of Problems Report in Section 3.4.3, above; however, this report displays data by problem code group only.

The Frequency of POV/Problem (Problem Code) Report Screen will be displayed.

Frequency of POV/Problem (Problem Code) Report. This report will generate a list of the top N POV/Problem (Problem Code) for contacts that you select. Enter beginning Contact Date for Search: January 1, 1996 (JAN 01, 1996) Enter ending Contact Date for Search: (1/1/96 - 6/25/97): JAN 01, 1996// T (JUN 25, 1997)

Frequency of POV/Problem (Problem Code) Report Screen

- Type the date you want to begin listing and counting primary POVs/problems at the “Enter beginning Contact Date for Search:” prompt and press <RETURN>.
- Type the date you want to stop listing and counting primary POVs/problems at the “Enter ending Contact Date for Search:” prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex).

- Type “S” at the “Select Action:” prompt and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.

- Type "Q" at the "Select Action:" prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed.

```
Select one of the following:
  P   PRIMARY POV Only
  S   PRIMARY and SECONDARY POV's

Include which POV's: P// RIMARY POV Only

Select one of the following:
  L   List of items with Counts
  B   Bar Chart (132 col)

Select Type of Report: L// ist of items with Counts
How many entries do you want in the list: (5-100): 10//

Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>
```

- Type the corresponding letter of the type of POV you want to print at the "Include which POV's:" prompt and press <RETURN>.
- Type the corresponding letter of the type of report you want to print at the "Select Type of Report:" prompt and press <RETURN>.
- Type the number of entries you want to print in the list at the "How many entries do you want in the list:" prompt and press <RETURN>.
- Type the corresponding letter of the type of output you want at the "Do you wish to:" prompt and press <RETURN>.

- Type the print device at the “Device:” prompt and press <RETURN>.

The Frequency of POV/Problem (Problem Code) Report will print, as displayed below.

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING				
REPORT REQUESTED BY: GILL,SUSAN				
The following contact listing contains MH/SS contacts selected based on the following criteria:				
RECORD SELECTION CRITERIA				
Encounter Date range: JAN 01, 1996 to JUN 25, 1997				
Patient Sex: FEMALE				
Report Type: FREQUENCY REPORT (TOP TEN)				
TOP 10 POV/Problem (Problem Code)'s.				
PRIMARY POV Only				
DATES: JAN 01, 1996 TO JUN 25, 1997				
No.	PROB CODE NARRATIVE	PROBLEM (POV) CODE#	RECS	ACT TIME (MINS)
1.	ABUSIVE BEHAVIOR (ALLEGED),EM	45.2	1	3
2.	ADULT/CHILD RELATIONSHIP	53	1	30
3.	DRUG WITHDRAWAL SYNDROME	11	1	1
4.	SLEEP DISORDER	22	1	3
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS RETURN:				

Frequency of POV/Problem (Problem Code) Report

3.4.5 Frequency of Problems by Problem Category

- To list and count the top primary POVs/problems (problem code groupings) for selected visits by problem category, type "FPRC" at the "Select Problem Specific Reports Option:" prompt and press <RETURN>.

NOTE: This report is similar to the Frequency of Problems Report in Section 3.4.3, above; however, this report displays data by problem code group only.

The Frequency of Problem/POV (Problem Category) Report will be displayed.

Frequency of Problem/POV (Problem Category) Report.

This report will generate a list of the top N Problem/POV (Problem Category) for contacts that you select.

Enter beginning Contact Date for Search: January 1, 1996 (JAN 01, 1996)

Enter ending Contact Date for Search: (1/1/96 - 6/25/97):JAN 01, 1996// T (JUN 25, 1997)

Frequency of Problem/POV (Problem Category) Report Screen

- Type the date you want to begin listing and counting primary POVs/problems at the "Enter beginning Contact Date for Search:" prompt and press <RETURN>.
- Type the date you want to stop listing and counting primary POVs/problems at the "Enter ending Contact Date for Search:" prompt and press <RETURN>.

The Visit Selection Menu will be displayed (see Section 3.1.6, Patients Seen by Age and Sex).

- Type "S" at the "Select Action:" prompt and press <RETURN>.
- Type the data items in the order you want to print them (e.g., 1,2,3) and press <RETURN>.
- After you select the data items and enter the requested information for each item, press <RETURN>.

- Type “Q” at the “Select Action:” prompt in the Visit Selection Menu and press <RETURN>.

The following screen will be displayed.

```
Select one of the following:
  P   PRIMARY POV Only
  S   PRIMARY and SECONDARY POV's

Include which POV's: P// RIMARY POV Only

Select one of the following:
  L   List of items with Counts
  B   Bar Chart (132 col)

Select Type of Report: L// ist of items with Counts
How many entries do you want in the list: (5-100): 10//

Select one of the following:
  P   PRINT Output
  B   BROWSE Output on Screen

Do you wish to : P// RINT Output
DEVICE: HOME// <RETURN>
```

- Type the corresponding letter of the type of POV you want to print at the “Include which POV's:” prompt and press <RETURN>.
- Type the corresponding letter of the type of report you want to print at the “Select Type of Report:” prompt and press <RETURN>.
- Type the number of entries you want to print in the list at the “How many entries do you want in the list:” prompt and press <RETURN>.
- Type the corresponding letter of the type of output you want at the “Do you wish to:” prompt and press <RETURN>.

- Type the print device at the "Device:" prompt and press <RETURN>.

The Frequency of POV/Problem (Problem Code) Report will print, as displayed below.
Below are samples of both report types.

MENTAL HEALTH/SOCIAL SERVICES RECORD LISTING				
REPORT REQUESTED BY: GILL,SUSAN				
The following contact listing contains MH/SS contacts selected based on the following criteria:				
RECORD SELECTION CRITERIA				
Encounter Date range: JAN 01, 1996 to JUN 25, 1997				
Patient Sex: FEMALE				
Report Type: FREQUENCY REPORT (TOP TEN)				
TOP 10 Problem/POV (Problem Category)'s.				
PRIMARY POV Only				
DATES: JAN 01, 1996 TO JUN 25, 1997				
No.	CATEGORY NARRATIVE	CATEGORY CODE	# RECS	ACT TIME (MINS)

1.	PSYCHOSOCIAL PROBLEMS	2	2	4
2.	ABUSE	3	1	3
3.	FAMILY LIFE PROBLEMS	5	1	30
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS RETURN:				

Frequency of POV/Problem (Problem Code) Report

3.5 PCC Management Reports

- To access the PCC Management Reports Menu, type "PCCM" at the IHS Mental Health/Social Services System Main Menu and press <RETURN>.

The PCC Management Reports Menu will be displayed. This option generates reports from the PCC and will retrieve only Mental Health/Social Services data that has been passed to the PCC. PCC Management Reports will not be covered in this manual. Refer to the respective user manual if you use this option.

```
*****  
**      PCC Management Reports      **  
*****  
Version 2.9  
ALBUQUERQUE HOSPITAL  
  
PLST  Patient Listings ...  
RES   Resource Allocation/Workload Reports ...  
INPT  Inpatient Reports ...  
QA    Quality Assurance Reports ...  
DM    Diabetes Program QA Audit ...  
APC   APC Reports ...  
PCCV  PCC Ambulatory Visit Reports ...  
BILL  Billing Reports ...  
BMI   Body Mass Index Reports ...  
ACT   Activity Reports by Discipline Group ...  
DR    PCC Patient Data Retrieval Utility  
RT    Report Template Utility ...  
STS   Search Template System ...  
QMAN  Q-Man (PCC Query Utility)  
FM    FileMan (General) ...  
  
Select PCC Management Reports Option:
```

PCC Management Reports Menu

3.6 Q-Man (PCC Query Utility)

- To access the Q-Man (PCC Query Utility) option, type “QMAN” at the IHS Mental Health/Social Services System Main Menu and press <RETURN>.

The Q-Man (PCC Query Utility) Screen will be displayed. This option generates reports from the PCC and will retrieve only Mental Health/Social Services data that has been passed to the PCC. Q-Man will not be covered in this manual. Refer to the respective user manual if you use this option.

```
***** WELCOME TO Q-MAN: THE PCC QUERY UTILITY *****

*****
**          WARNING...Q-Man produces confidential patient information.          **
**          View only in private.  Keep all printed reports in a secure area.    **
**          Ask your site manager for the current Q-Man Users Guide.            **
*****

Query utility: IHS Q-MAN Ver. 2
Current user: SUSAN GILL
Chart numbers will be displayed for: ALBUQUERQUE HOSPITAL
Access to demographic data: PERMITTED
Access to clinical data: PERMITTED
Programmer privileges: YES

Enter RETURN to continue or '^' to exit:

***** Q-MAN OPTIONS *****

Select one of the following:

1    SEARCH PCC Database (dialogue interface)
2    FAST Facts (natural language interface)
3    RUN Search Logic
4    VIEW/DELETE Taxonomies and Search Templates
5    FILEMAN Print
9    HELP
0    EXIT

Your choice: SEARCH//
```

Q-Man (PCC Query Utility) Screen

3.7 Print Standard MH/SS Tables

- To access Print MHSS Standard Tables Menu, type “TABL” at the IHS Mental Health/Social Services System Main Menu and press <RETURN>.

The Print MHSS Standard Tables Menu will be displayed. Use the Print Standard MH/SS Tables option to print some of the standard codes required for data entry and coding functions of the Mental Health/Social Services package.

The standard tables you can print from the Mental Health/Social Services package are shown in the menu below.

```
*****  
**      IHS Mental Health/Social Services System      **  
**              Print MHSS Standard Tables              **  
*****  
                          Version 2.0  
  
                        ALBUQUERQUE HOSPITAL  
  
ACT  Print Activity Code Table  
CLN  Print Clinic Codes  
DSM  Print MH/SS Problem/DSM IV Table  
PROB Print MH/SS Problem Codes  
  
Select Print Standard MH/SS Tables Option:  
  
DEVICE:
```

Print MHSS Standard Tables Menu

- To print any of the above tables, type the corresponding letters of the table you want to print at the “Select Print Standard MH/SS Tables Option:” prompt and press <RETURN>.
- Type a print device at the “Device:” prompt and press <RETURN>.

The table you selected will print.

4.0 Manager Utilities Module

The Manager Utilities module provides options for Site Managers and program supervisors to customize the MH/SS system to suite their site's needs. Options are also available for administrative functions, including the export of data to the Area, re-setting local flag fields, and verifying users who have edited particular patient records.

- **To access the Manager Utilities Menu, type "MUTL" at the IHS Mental Health/Social Services System Main Menu and press <RETURN>.**

The Manager Utilities Menu will be displayed.

```
*****  
**      IHS Mental Health/Social Services System      **  
**                               Manager Utilities                               **  
*****  
                               Version 2.0  
  
                               ALBUQUERQUE HOSPITAL  
  
SITE      Update Site Parameters  
EXPT      Export Utility Menu ...  
RPF       Re-Set Patient Flag Field Data  
DLWE      Display Log of Who Edited Record  
ELSS      Add/Edit Local Service Sites  
EPHX      Add Personal History Factors to Table  
  
Select Manager Utilities Option:
```

Manager Utilities Menu

4.1 Update Site Parameters

Individual sites use the Site Parameters file to set the MH/SS system to suit their program needs. Use the Update Site Parameters option to modify the parameters in this file. The most important specification in this file is the determination of the types and classification of data that passes from the MH/SS system to the PCC. Instructions and descriptions are provided here for all fields in the Site Parameters file. For a detailed discussion on passing data to the PCC, refer to the next Section , MH/SS to PCC Link.

- **To update site parameters, type “SITE” at the “Select Manager Utilities Option:” prompt in the Manager Utilities Menu and press <RETURN>.**

The “Select MHSS Site Parameters:” prompt will be displayed.

- Type the name of the parameter you want to update at the “Select MHSS Site Parameters:” prompt and press <RETURN>.

The Update MH/SS Site Parameters Screen will be displayed. This screen is the same as that in Section 2.1, Update MH/SS Encounter Data – Screen Entry. See Section 2.1 for information on how to enter, modify, and delete data.

** UPDATE MH/SS SITE PARAMETERS ** Site Name: FORT MOJAVE TRIBE	

***** DEFAULT VALUES IN DATA ENTRY *****	
MH Location: FORT MOJAVE TRIBE	SS Location: FORT MOJAVE TRIBE
MH Community: COLORADO UNK	SS Community: COLORADO UNK
MH Clinic: MENTAL HEALTH	SS Clinic: MEDICAL SOCIAL SERVI
Type of Contact:	Appt/Walk In:

Default Health Summary Type: MENTAL HEALTH/SOCIAL SERVICES	
Full Data Entry (SOAP asked)? YES	Ask Interpreter Utilized? NO
Default Device (data export): FILE (UN	Universal/Site Spec. Lookup: SITE SPE
Default response on form print: FULL	Suppress Comment on Suppressed Form?
# of past POVs to display:	Exclude No Shows on last DX Display?

***** PCC INTERFACE PARAMETERS *****	
Type of Visit to Create in PCC: IHS	Allow PCC Problem List Update? YE
Type of PCC Link: MH/SS DEVELOPED CROS	PCC Link Exceptions (return):

Update MH/SS Site Parameters Screen

DEFAULT VALUES. In the Site Parameters file, you may enter several default values that make data entry faster and easier for MH/SS system users. You can enter different values for Mental Health and Social Services programs. The data you enter in each of the fields described below will automatically be displayed on the data entry screens and as the default values for the roll-and-scroll data entry method.

MH/SS LOCATION. Enter the location at which the program visits take place.

MH/SS COMMUNITY. Enter the community in which the program visits occur.

MH/SS CLINIC. Enter the type of clinic during which the visits occur.

TYPE OF CONTACT. Enter the type of contact setting or code (e.g., Administrative, Chart Review, etc.).

APPT/WALK IN. Enter the type of visit that occurred (e.g., appointment, walk in, or unspecified).

DEFAULT HEALTH SUMMARY TYPE. Specify the type of health summary printed from within the Mental Health/Social Services package. Typically, this default value is the Mental/Health Social Services summary type. Refer to the Health Summary System Manuals for further information on the available types.

FULL DATA ENTRY (SOAP ASKED). Respond “Yes” to have the chief complaint and subjective/objective prompts displayed in the roll-and-scroll method. Otherwise, respond “No” and the prompts will not be used. These fields are typically not used when data entry staff are using this method for entering data from forms that providers have completed, since the provider-completed form with these fields completed will be filed in the patient’s MH/SS record. The Full Data Entry field has no effect on the screen format for data entry.

DEFAULT DEVICE (DATA EXPORT). In this field, enter the device to which your data export files should be copied. For most sites, the entry in this field will be “File.”

- F File (UNIX UCPPUBLIC or DOS)
- D Diskette (Floppy)
- C Cartridge Tape
- T 9-Track Tape

DEFAULT RESPONSE ON FORM PRINT. When you print a Mental Health/Social Services record, the type entered will be the default value for the type of form that prints. Select from:

- F Full Encounter Form
- S Suppress Subjective/Objective and Chief Complaint
- B Both

OF PAST POVS TO DISPLAY. Enter the number of the past POVS. This response must be a number.

ASK INTERPRETER UTILIZED. This field affects only the roll-and-scroll data entry method. Enter “Yes” in this field to display the Interpreter Utilized field during this data entry process for use at sites who will be recording the presence of an interpreter during MH/SS visits. If you enter “No,” this prompt will not be displayed. The screen format data entry process is not affected.

UNIVERSAL/SITE SPEC LOOKUP. In this field, specify whether the patient lookup process will use only the file of patient's registered at your facility or at all facilities within your RPMS system. Enter Universal for patient lookup at all facilities or Site specific for only patients registered at your site.

SUPPRESS COMMENTS ON SUPPRESSED FORM? Enter “Yes” or “No” to indicate if you want to suppress the provider's comments.

EXCLUDE NO SHOWS ON LAST DX DISPLAY? Enter “1” (Yes) or “0” (No) to indicate if you want the number of patients who did not show up for visits excluded or included in the DX Display.

TYPE OF VISIT TO CREATE IN PCC. Use this field to determine the type of visit created from the encounter record you enter into the MH/SS system. Select one of the following entries, depending on the classification of the Mental Health and Social Services programs at your facility:

- I IHS
- C Contract
- 6 638 Program
- T Tribal
- O Other
- V VA

TYPE OF PCC LINK. Your entry in this field determines the type of data that passes from the MH/SS system to the PCC (see MH/SS to PCC Link Section in the Appendix for details on how MH/SS and PCC link). Select one of the following:

1. No Link Active
2. Pass STND Code and Narrative
3. MH/SS Developed Crosswalk
4. Pass All Data as Entered (No Masking)
5. Pass Codes and Canned Narrative

For options 2 and 5, the following screen will be displayed after you press <RETURN>. With each of these link types, some standard data is passed to the PCC. You can specify those standards using this screen. The standard code, shown in the first line of the screen, will be passed if using Option 2. The narrative entered will be the only narrative passed if you have selected Option 2 or 5.

Standard Code to Use (Option 2 ONLY): V65.40
Narrative for MH Program: MH/SS/SA COUNSELING
Narrative for SS Program: SS VISIT

Refer to the following section, MH/SS to PCC Link, for details on each of the link options and the specific data that is passed.

ALLOW PCC PROBLEM LIST UPDATE. To update a patient's PCC problem list from within the MH/SS system, enter "Yes" in this field. Enter "No" if you do not want users to be able to update the PCC problem list.

PCC LINK EXCEPTIONS. Use this option to set data passing parameters for individuals that are different from the program default. For example, if a Tribal program, using a low level passing option (like 2 or 5) for its program staff has a consulting psychiatrist who wants appropriate clinical encounter data passed routinely to PCC (either using the IHS standard with partial masking, or the open passing option), may use this option to meet this need.

Provider Name	Type of PCC Link for this Provider
SMITH,LORRAINE	NO LINK ACTIVE
CUT,BILL	PASS CODE AND STND NARRATIVE
LOPEZ,GREG	PASS STND CODE AND NARRATIVE
MARTIN,MARY	PASS ALL DATA AS ENTERED

4.2 Export Utility Menu

The functions on the Export Utilities Menu are used for passing data from your facility to the IHS Headquarters office for statistical reporting purposes.

IMPORTANT: This set of utilities should only be accessed and used by the Site Manager. If you are able to access to this menu, please advise the Site Manager immediately and do not use any of these options.

These utilities should be familiar to Site Managers. Recommended sequence for their use follows those from PCC- CHK, clean, GEN, DISP, ERRS, transmit. RGEN, RSET and OUP should be reserved for expert use as required.

- **To pass data from your facility to Headquarters, type “EXPT” at the “Select Manager Utilities Option:” prompt in the Manager Utilities Menu and press <RETURN>.**

The Export Utility Menu will be displayed. The options in this menu are detailed in the following subsections. Section 4.2.9 displays a list of MH/SS Extract Record Definitions.

```
*****
**      IHS Mental Health/Social Services System      **
**                               Export Utility          **
*****
                               Version 2.0

                        ALBUQUERQUE HOSPITAL

GEN   Generate MHSS Transactions for HQ
DISP  Display a Log Entry
PRNT  Print Export Log
RGEN  Re-generate Transactions
RSET  Re-set Data Export Log
CHK   Check Records Before Export
ERRS  Print Error List for Export
OUTP  Create OUTPUT File

Select Export Utility Menu Option:
```

Export Utility Menu

4.2.1 Generate MHSS Transactions for HQ

This routine will generate MH/SS transactions to HQ. The transactions are for records posted between a specified range of dates. If you type “^” at any prompt, you will be asked to confirm your entries before generating transactions.

- To generate MH/SS transactions to Headquarters, type “GEN” at the “Select Export Utility Menu Option:” prompt and press <RETURN>.
- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

The following screen is an example of the output that will be displayed.

```
Enter beginning date for this run: SEP 1, 1994

The inclusive dates for this run are SEP 1, 1994 THROUGH SEP 28, 1994
The location for this run is the _____HOSPITAL/CLINIC.

Do you want to continue (Y/N) N// <Y>

Generating transactions. Counting records ( * 100* )

*100* Transactions were generated.
Updating log entry.
Deleting cross-reference entries (100)

RUN TIME (H.M.S): 0.3.56
```

4.2.2 Display a Log Entry

- To display a log entry, type “DISP” at the “Select Export Utility Menu Option:” prompt and press <RETURN>.
- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

The following screen is an example of the output that will be displayed.

```
Information for Log Entry Beginning Date: <SEP 1, 1994>
NUMBER: 2          BEGINNING DATE: SEP 1, 1994
ENDING DATE: SEP 30, 1994@10:26:49
RUN STOP DATE/TIME: OCT 2, 1994@10:30:51
COUNT OF ERRORS: 2    COUNT OF TRANSACTIONS: 98
COUNT OF RECORDS PROCESSED: 100    RUN LOCATION: _____
# ADDS: 97          # MODS: 1
# DELETES: 0
TRANSMISSION STATUS: SUCCESSFULLY COMPLETED
```

4.2.3 Print Export Log

- To print an export log, type “PRNT” at the “Select Export Utility Menu Option:” prompt and press <RETURN>.
- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

The following screen is an example of the output that will be displayed.

```
COUNT OF ERRORS: 2    COUNT OF TRANSACTIONS: 98
COUNT OF RECORDS PROCESSED: 100 RUN LOCATION: _____

*****MENTAL HEALTH/SOCIAL SERVICES*****
*****EXPORT EXTRACT LOG*****                PAGE 1
REPORT DATE: 10-2-94

          ADD DEL    MOD  TRAN  ERROR  RECORD
=====
08/01/94 09/02/94 200    0    220    202    100    302
09/01/94 10/02/94    97    0     1     98     2     100
          ----  ----  ----  ----  ----  ----
          TOTAL          297    0    221    300    102    402
```

4.2.4 Re-generate Transactions

WARNING: DO NOT USE THIS OPTION IF YOU ARE NOT SURE WHAT YOU ARE DOING.

- To re-generate a transaction, type "RGEN" at the "Select Export Utility Menu Option:" prompt and press <RETURN>.
- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

The following screen is an example of what will be displayed.

```
Select MHSS EXTRACT LOG BEGINNING DATE: 6    3-2-1997

Log entry 6 was for date range MAR 2, 1997 through JUN 16, 1997
And generated 44 transactions from 67 records.

This routine will generate    transactions.

Do you want to regenerate the transactions for this run? N//
```

4.2.5 Re-set Data Export Log

- To re-set the MHSS Data Transmission Log, type "RSET" at the "Select Export Utility Menu Option:" prompt and press <RETURN>.

WARNING: You must be absolutely sure that you have corrected the underlying problem that caused the Transmission process to fail in the first place. The MHSS Data Transmission log entry you select will be REMOVED from the log file and all Utility and Data globals associated with that run will be killed.

- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

See Section 4.2.4, Re-generate Transactions, above for an example of output.

4.2.6 Check Records Before Export

- To review all records that have been posted to the MH/SS database since the last export was performed, type “CHK” at the “Select Export Utility Menu Option:” prompt and press <RETURN>.

NOTE: This option will review all records that were posted from the day after the last date of that run up until two days ago.

- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

The following screen is an example of what will be displayed.

```

Last run was for   AUG 1, 1994   through AUG 31, 1994

This report will review records that were posted between   SEP 1, 1994   and SEP 30, 1994.

Do you want to continue?  Y// <RETURN>

                          MHSS EXTRACT LOG ERROR REPORT   OCT 2, 1994  PAGE 1

VISIT DATE                PATIENT                HRN  PGM  ACT
                                TYPE  TYPE
-----
SEP 1, 1993  12:30  WATERMAN,RAE JESSICA  256  M  INPATIENT  12
ERROR: E022-NO PROVIDER OF SERVICE

SEP 9, 1993  14:30  WINDERBEAN,JASON      1256  M  FIELD      33
ERROR: E023-NO AFFILIATION FOR PROVIDER

SEP 11, 1993  08:30  SMITH,FAY              10256  M  INPATIENT  13
ERROR: E010-NO TYPE OF CONTACT

SEP 20, 1993  09:30  WATERMAN,RAE JESSICA  256   M  INPATIENT  12
ERROR: E022-NO PROVIDER OF SERVICE

NOTE: See The MH/SS Transaction Error Code List For Error Code Descriptions.

***These errors should be corrected prior to the next Export/Generation***
Otherwise, these records will not Export and will also appear on the
ERRS (Print Error List for Export) Report after the next Generation.
    
```

4.2.7 Print Error List for Export

- To review all records that have been posted to the MHSS database and are still in error AFTER the latest Export/Generation, type "ERRS" at the "Select Export Utility Menu Option:" prompt and press <RETURN>.

NOTE: The Check Records Before Export option (Section 4.2.6) should have been used to determine all errors before running the generation. You may now correct these errors before the next Export/Generation.

- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

The following screen is an example of what will be displayed.

Select MHSS EXTRACT LOG BEGINNING DATE: <SEP 1, 1994>						
MHSS EXTRACT LOG ERROR REPORT			OCT 2, 1994	PAGE 1		
VISIT DATE	PATIENT	HRN	PGM	ACT TYPE	TYPE	

SEP 9, 1993 14:30	WINDERBEAN,JASON	1256	M	FIELD	33	
ERROR: E023-NO AFFILIATION FORPROVIDER						
SEP 11, 1993 08:30	SMITH,FAY	10256	M	INPATIENT	13	
ERROR: E010-NO TYPE OF CONTACT						

NOTE: See The MHSS Transaction Error Code List for Error Code Descriptions (displayed below).

MH/SS Transaction Error Codes List

CODE	DESCRIPTION
E001	No Date of Service
E002	ASUFAC in Location Table for Dux(2) is Missing
E003	Program Code Missing
E004	Location of Service is Missing
E005	Location of Service ASUFAC Invalid
E006	No Community of Service

E007	ST CNTY Community Code Invalid
E008	Area SU Community Code Invalid
E009	No Activity Code
E010	No Type of Contact
E011	No. Served Less Than 1
E012	Activity Minutes is Missing or 0
E013	No. HRN's for Patient
E014	No Sex in Patient's File
E015	Patient Missing DOB
E016	No Community of Residence
E017	Invalid Community Pointer
E018	No Tribe of Membership
E019	Old Unused Tribe Code
E020	No Tribe Code
E021	No Purpose of Visit
E022	No Provider of Service
E023	No Affiliation for Provider
E024	No Discipline for Provider
E025	No Initials for Provider

4.2.8 Create Output File

- To create an output file, type “OUTP” at the “Select Export Utility Menu Option:” prompt and press <RETURN>.
- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

4.2.9 Mental Health and Social Services Extract Record Definition

Total record length: 152 characters

<u>CHAR POS.</u>	<u>LENGTH</u>	<u>ITEM NAME</u>	<u>DESCRIPTION/EDITS</u>
1	1	Record Type	Type of record. A=Add
2-8	7	Date of Service	Internal FM Format. CYYMMDD Example: 2940312
9-14	6	Loc. of Data	Location of computer where data transaction was generated. ASUFAC. Example: 202022
15	1	Program Type	M=Mental Health S=Social Services O=Other
16-21	6	Loc. of Encounter	Location where the encounter took place ASUFAC. Example: 202022
22-28	7	Comm. of Service	Community of Service, STCTYCOM code.
29-35	7	Comm. of Service	Community of Service, ASUCOMM code.
36-37	2	Activity Code	2 digit Activity Code. See standard activity code table.
38	1	Type of Contact	1 digit Type of Contact code. 1=ADMINISTRATIVE OFFICE 2=OUTPATIENT 3=INPATIENT 4=FIELD 5=HOME 6=SCHOOL 7=CHART REVIEW 8=TELEPHONE 9=EMERGENCY ROOM 10=CONSULTATION

39-41	3	# served	Number served. filled.	Numeric, left zero Example: 001,323,020
42-46	5		Activity time	Activity time in minutes. Left zero filled. 00060, 00003, 00600
47	1		Inpatient disposition	Inpatient Disposition. 1=INPATIENT PSYCH 2=IHS HOSPITAL 3=RESIDENT 4=SHELTER 5=PARTIAL CARE 6=INPATIENT MEDICAL 7=ALCOHOL/DRUG REHAB 8=LONG TERM CARE Blank is valid and acceptable.
48	1		APPT/WALK-IN	Appointment/Walk-In A=APPOINTMENT W=WALK-IN U=UNSPECIFIED Blank is valid and acceptable.
49	1	Interpreter Util.	Interpreter Utilized. Y=YES N=NO Blank is valid and acceptable.	
50-55	6	Primary Provider	Primary Provider.	Affiliation,
50	1	Affiliation	Discipline Code and Initials.	
51-52	2	Discipline Code	Initials are left blank filled.	
53-55	3	Initials	Example: 114BD, 180LAB	
56-61	6	Secondary Provider#1	Secondary Provider.	Affiliation,
56	1	Affiliation	Discipline Code and Initials.	
57-58	2	Discipline code	Initials are left blank filled.	
59-61	3	Initials	Example: 114BD, 180LAB	
62-67	6	Secondary Provider#2	Next Secondary Provider.	Affiliation, Discipline Code and Initials. (As Above)

68-73	6	Secondary Provider#3	Next Secondary Provider. Affiliation, Discipline Code and Initials. (As Above)
74-79	6	Purpose of Visit 1	Problem Code or DSMIV Diagnosis. Examples: 20, 311.,300.30, 18 Left blank filled.
80-85	6	Purpose of Visit 2	Problem Code or DSMIV Diagnosis. Examples: 20, 311.,300.30, 18 Left blank filled.
86-91	6	Purpose of Visit 3	Problem Code or DSMIV Diagnosis. Examples: 20, 311.,300.30, 18 Left blank filled.
92-97	6	Purpose of Visit 4	Problem Code or DSMIV Diagnosis. Examples: 20, 311.,300.30, 18 Left blank filled.
98-109 for	12	Patient Identifier	Artificially derived site specific Identifier unduplicated counts.
1101		Sex of Patient	F=FEMALE M=MALE
111-117	7	DOB of Patient	Internal FM Format. CYYMMDD Example: 2940312
118-124	7	Comm. of Residence	STCTYCOM code of patient's community of residence.
125-131	7	Comm. of Residence	ASUCOM code of patient's community of residence.
132-134	3	Tribe Code	Code of patient's tribe of membership. Example: 096
1351		Medicare Eligible	If patient was eligible for Medicare on the date of encounter, this field will contain a Y, otherwise, it will contain a N.
1361		Medicaid Eligible	If patient was eligible for Medicaid on the date of encounter, this field will contain a Y, otherwise, it will contain a N.

1371		Private Ins. Eligible	If patient is eligible for Private Insurance on the date of encounter, this field will in contain a Y, otherwise, it will contain a N.
138-142	5	Level of Service	5 digit Evaluation and Management Services Codes from Physicians' Current Procedural Terminology (CPT).
143-147	5	Procedures/Services	5 digit Psychiatric Services (Primary) Code from Physicians' Current Procedural Terminology (CPT)
148-152	5	Procedures/Services	5 digit Psychiatric Services (Secondary) Code (CPT)

4.3 Re-Set Patient Flag Field Data

Use this option to reset the patient flag field in all of the patient files. You can reset one particular flag or all flags. You may use this reset option to reassign a particular flag or all flags as needed.

NOTE: This option resets the patient flag field only. It will **not** reset the visit flag fields.

- **To reset the patient flag field in all patient files, type “RPF” at the “Select Manager Utilities Option:” prompt in the Manager Utilities Menu and press <RETURN>.**

The screen below will be displayed.

- Type information as requested at the prompts that follow and press <RETURN> to record each entry.

This option will reset all patient flag fields to null. This should be done each time you want to flag patients for a different reason.

Select one of the following:

- A ALL FLAGS
- O ONE PARTICULAR FLAG

Reset which flags: A// ONE PARTICULAR FLAG

Which flag should be removed: 1

Are you sure you want to do this? N// YES

Hold on... resetting data..

All done.

4.4 Display Log of Who Edited Record

Use this option to print a list people who have edited a particular patient record.

- To print a list of people who have edited a patient record, type “DLWE” at the “Select Manager Utilities Option:” prompt in the Manager Utilities Menu and press <RETURN>.

The “Enter Encounter Date:” will be displayed.

```
Enter ENCOUNTER DATE: 2/26/97 (FEB 26, 1997) (FEB 26, 1997)
Enter LOCATION OF ENCOUNTER (if known, otherwise press return):SELLS
HOSPITAL

Enter PATIENT (if known, otherwise press return): WILLIAMS,SUE
                F 01-01-63 000170001 SE 256345
DEVICE: HOME   RIGHT MARGIN: 80// <RETURN>

                MHSS RECORD LIST                FEB 27,1997 16:25 PAGE 1
DATE
CREATED WHO ENTERED RECORD LAST MOD USER LAST UPDATE
                DATE/TIME EDITED WHO EDITED
-----
02/26/97 BUTCHER,LORI ANN 02/26/97 BUTCHER,LORI ANN
                FEB 26,1997 07:29 BUTCHER,LORI ANN
                FEB 27,1997 08:40 DOUGLAS,BILL
                FEB 28,1997 13:57 MARTINEZ,NANCY

End of report. Press return:
```

- Type information as requested at the prompts that follow and press <RETURN> to record each entry, as displayed above.

4.5 Add/Edit Local Service Sites

Use this option to define (add) local service sites. You may capture visit data at locally identified locations (e.g., Visits at a Clinic in a School). Counts of these visits can be recovered using the “GEN” option in Encounter Reports or “ACT” in the Workload reports.

- **To define a local service site, type “ELSS” at the “Select Manager Utilities Option:” prompt in the Manager Utilities Menu and press <RETURN>.**

The “Select MHSS Local Service Sites:” prompt will be displayed.

- Type information as requested at the prompts that follow and press <RETURN> to record each entry, as displayed below.

```
Select MHSS LOCAL SERVICE SITES: Local School
Are you adding 'Local School' as
a new MHSS LOCAL SERVICE SITES (the 2ND)? Y (Yes)
LOCAL SERVICE SITE: Local School//
ABBREVIATION: LS

Select MHSS LOCAL SERVICE SITES:
```

4.6 Add Personal History Factors to Table

Use this option to add Personal History items to the four item list initially identified for use in MH/SS programs. Added items will be shown as items in the Personal History field any place this option exists in a Select or Print field in the GEN reports.

- **To add a Personal History item, type “EPHX” at the “Select Manager Utilities Option:” prompt in the Manager Utilities Menu and press <RETURN>.**

The “Enter a Personal History Factor:” prompt will be displayed.

- Type information as requested at the prompts that follow and press <RETURN> to record each entry, as displayed below.

```
Select Manager Utilities Option: EPHX Add Personal History Factors to Table

Enter a PERSONAL HISTORY FACTOR: Explosive Violence
Are you adding 'Explosive Violence' as
a new MHSS PERSONAL HX FACTORS (the 5TH)? y (Yes)
FACTOR: Explosive Violence//

Enter a PERSONAL HISTORY FACTOR:
```


Appendix

Data Entry Screen Help

When you enter and modify data, use the following commands to navigate through the data entry screens.

Cursor Movement

Move right one character	<Right>
Move left one character	<Left>
Move right one word	<Ctrl-L> or <PF1><Space>
Move left one word	<Ctrl-J>
Move to right of window	<PF1><Right>
Move to left of window	<PF1><Left>
Move to end of field	<PF1><PF1><Right>
Move to beginning of field	<PF1><PF1><Left>

Modes

Insert/Replace toggle	<PF3>
Zoom (invoke multiline editor)	<PF1>Z

Deletions

Character under cursor	<PF2> or <Delete>
Character left of cursor	<Backspace>
From cursor to end of word	<Ctrl-W>
From cursor to end of field	<PF1><PF2>
Toggle null/last edit/default	<PF1>D or <Ctrl-U>

Macro Movement

Field below	<Down>
Field above	<Up>
Field to right	<Tab>
Field to left	<PF4>
Pre-defined order	<Return>
Next page	<PF1><Down> or <Page Down>
Previous page	<PF1><Up> or <Page Up>
Next block	<PF1><PF4>
Jump to a field	^caption
Go to command line	^
Go into multiple or word- processing field	<Return>

Command Line Options

Enter the up-hat (^) at any field to jump to the command line.

Command	Description
Exit	Exit form (asks whether changes should be saved)
Close	Close window and return to previous level
Save	Save changes
Next page	Go to next page
Refresh	Repaint screen

Other Shortcut Keys

Exit form and save changes	<PF1>E
Quit form without saving changes	<PF1>Q
Invoke Record Selection Page	<PF1>L

Word-Processing Screen Help

The following options are helpful for using the word-processing screens in the RCIS.

Edit Options

The options below are available for editing text that has been entered into a word-processing field. To use one of the options, type the first letter of the command at the EDIT prompt.

- Add Lines to End of Text
- Break a Line into Two
- Change Every String to Another in a Range of Lines
- Delete Line(s)
- Edit a Line (Replace __ with __)
- Insert Line(s) after an Existing Line
- Join Line to the One Following
- List a Range of Lines
- Move Lines to New Location within Text
- Print Lines as Formatted Output
- Repeat Lines at a New Location
- Search for a String
- Transfer Lines from Another Document
- Utility Sub-Menu

Utility Sub-Menu

The options below are available from the utility sub-menu. To use one of these options, type the first letter of the command.

- Editor Change
- File Transfer from Foreign CPU
- Text-Terminator-String Change

**INSTRUCTIONS
FOR FILLING OUT
MENTAL HEALTH AND SOCIAL SERVICES
PCC REPORTING FORM (IHS-524)**

<u>ITEM</u>	<u>COMMENT</u>
* Date	Date activity took place.
Arrival Time	Outpatient contacts only enter time. Emergency Room is considered an Outpatient visit.
* Program	Use M, S or O to indicate program affiliation of primary provider.
Clinic	Type of clinic when the effort is within the context of a scheduled clinic other than MH or SS.
App't/Walk-in	Indicate whether patient had an appointment or not.
Problem List Update	To change the status of existing problems, use the boxes at the top of the page in conjunction with the patient's current health summary. A problem may be removed or its status changed to active or inactive by entering the problem number (from the health summary) in the appropriate box. A removed problem is actually deleted from the system and not available for future retrieval purposes.
Flag	A Ten-Digit (0-9) undefined Code for Local use.
* Provider Code	Each person providing a service to the patient should record his or her provider code in the upper right corner of the form, with the primary provider using the indicated line. Site Managers will assign Provider Codes made up of:
Affiliation	Affiliation, using standard IHS codes,
Discipline	Appropriate Discipline Code,
Provider Initials	Provider Initials.

INSTRUCTIONS
PAGE 2

<u>ITEM</u>	<u>COMMENT</u>
Designated Provider	Designated Providers can be identified for specific patients. Programs who wish to use this feature should make sure that all staff are aware of how the designation is being used.
Open/Admit/Close	<p>Allows for Program definitions of "Caseness" to identify Illness Episodes. Check appropriate Box for this action on this patient on this date.</p> <p>Suggested Definitions:</p> <p>OPEN First contact for this episode of this illness,</p> <p>ADMIT Problem defined, treatment plan in place, begin period of treatment.</p> <p>CLOSE Treatment for this episode of this illness discontinued.</p>
Disposition	<p>Any time a case is "Closed", the Disposition should be coded as:</p> <ol style="list-style-type: none">1- Completed Treatment, Stable2- Referred to Other Source3- Mutual Agreement to Terminate4- Administrative Termination5- Patient Dropped Out of Treatment6- Patient Moved7- Patient Died8- Other
*Community	Community where activity took place. Use three digit code from IHS standard STCOCOMM list or community name.

INSTRUCTIONS
PAGE 3

<u>ITEM</u>	<u>COMMENT</u>
*Activity	Use two digit activity codes from attached definitions. Use only one activity code for each record.
*Number Served	Use up to three digits to specify number of persons directly served by reported activity. Use 1 for direct patient care.
*Activity/Service Time	Record activity time in minutes. Up to three digits can be entered.
*Type of Contact	Check the most appropriate designation from the following categories: <ol style="list-style-type: none">1- Administrative2- Outpatient Clinic3- Inpatient4- Field5- Home6- School7- Chart Review8- Telephone9- Emergency Room10- Consultation
*Chief Complaint Subjective/Objective	Record narrative information on the nature of the activity being reported. For direct patient this should include the narrative history, physical examination and progress notes, and/or the subjective/objective observations of the provider.

INSTRUCTIONS
PAGE 4

<u>ITEM</u>	<u>COMMENT</u>
AXIS IV Major Psychosocial or Environmental	Use ONE of the following codes to identify the major Problem where relevant. Use additional MH/SS Problem Codes Problem to further specify, amplify or modify. 1- Primary Support Group Problem(s) 2- Social Environmental Problem(s) 3- Educational Problem(s) 4- Occupational Problem(s) 5- Housing Problem(s) 6- Economic Problem(s) 7- Access to Health Care Services Problem(s) 8- Legal Interaction Problem(s) 9- Other Psychosocial and Environmental Problem(s)
AXIS V Functional Level	For each contact, code patient's functional level using GAF scale (0-100) from DSM.
Interpreter Required	The Interpreter Required box should only be checked when there is a specific need for this service and should not be used as a substitute for recording effort where the secondary provider is considered as a co-therapist.
Add problem to PCC Problem List	Check if you want to add problem to the PCC Problem List. You can only remove or modify a problem in PCC with PCC Ambulatory Encounter Record.
Add Problem to MH/SS Problem List	Add a problem to the MH/SS Problem List.

INSTRUCTIONS
PAGE 5

<u>ITEM</u>	<u>COMMENT</u>
*MH/SS Purpose of Visit	Enter at least one, and up to three, purpose of visit codes OR DSM IV diagnostic codes (Axis I and/or Axis II). Note that the first line is used to identify the primary purpose of visit.
*Narrative	Brief narrative description of problem being addressed.
Inpatient Disposition	Use only where hospitalization is a necessary or appropriate action. Identify the type of facility. Enter appropriate code and name of facility in the free text field. <ol style="list-style-type: none">1 Inpatient Psych2 IHS Hospital3 Resident4 Shelter5 Partial Care6 Inpatient Medical7 Alcohol/Drug Rehab.8 Long Term Care
Level of Service Code	The Level of Service Code (codes to be determined).
Medical Problem Narrative	Enter narrative description of problem where medical services beyond MH are required. Primarily for those situations where providers (mainly Psychiatrists) are the primary care provider for other non-psychiatric conditions.
Personal History	Check appropriate boxes. This data will be added to the patient's history file, so once it is entered it is not necessary to repeat this addition each visit.

INSTRUCTIONS
PAGE 6

ITEM

COMMENT

NOTE: Problems **MUST** be on the MH/SS Problem List before Treatment Notes can be added to the File. The next five items pertain to adding or modifying Treatment Notes appended to Problems on the MH/SS Problem List.

Problem # - Refers to the problem identifier shown in the patient's health summary, or to the problem identified in the POV field immediately above when the problem has not previously been identified for this patient (i.e., no problem code for this issue is shown in the patient's health summary).

Short Range Treatment Plan Check if treatment plan is to be considered short-term.

Long Range Treatment Plan Check to identify long-range treatment plan.

Treatment Plan Note Enter narrative descriptive note on treatment.

Remove Plan # Identify treatment plan you want to remove from the patient's file. Can only be used to remove treatment plans shown in the patient's health summary.

Procedures Code(s) Use appropriate CPT codes to characterize actions taken.

Medications Prescribed Note medications prescribed this visit. This section will be used by pharmacy to fill prescriptions.

Comment Free text field to record other pertinent information, up to 200 characters.

***HR#** Patient's Health Record Number.

INSTRUCTIONS
PAGE 7

<u>ITEM</u>	<u>COMMENT</u>
*Patient Identifier	Age, Sex, Tribe and Community of Residence will be added to record from Registration module when patient is properly identified.
38. Sex	Gender of client/patient.
39. Tribe	Tribal affiliation of services recipient. Standard IHS Tribal Codes.
40. Date of Birth	Age of client/patient receiving services in years.
41. Residence	Current domicile.
*Facility	Facility where patient's medical record identified above is located.
*Location	Location of activity when it is not at the Facility. Use two digit location code from standard IHS codes. (Nursing Home, HC, Hospital, etc.)
Revisit/Referral to:	Tearoff for Patient's next visit or as a referral slip. Specify purpose of referral.
Instructions to Patient	Brief summary and instructions to patient.
*Provider Signature	Signature of Provider.

*These are all **Required Fields**. A record cannot be entered into the system if any of these items are not answered.

Specific Instructions

This section provides instruction for the MH/SS Ambulatory Encounter Record (IHS-524), item by item, in the order that users complete the form.

1. Patient and Visit Identification

When this form is used for an outpatient clinic visit, this section is usually completed by health records personnel by imprinting the patient's plastic identification card, which is kept in the health record.

For after-hours visits, field contacts or other contacts where the information is not filled out using the recipients' ID card, providers are responsible for providing sufficient information to assure that the patient can be identified in from the Patient Registration file, this would include, minimally, the patient's name, sex and birthdate. Add the Health Record # if known.

The patient's community of residence, social security number and tribal affiliation fields are optional.

Facility is the location of the PCC system the data are being recorded in, and;

Location is where the services were provided, **IF** this location was somewhere other than the **Facility**. All Service Units have extended sets of location codes reflecting Health Centers, Health Stations, Schools, Offices, Home, CHS Locations, etc., precisely for this purpose. Use these codes when location is relevant.

2. Administrative Data

The data items in the upper left-hand corner of the form are used to indicate the date of service and the program the provider is affiliated with.

The Arrival Time field **MUST** be filled out for Outpatient Visits. Please do not make the data entry person add all records using the default field 12:00 AM, mark the appropriate time in this field and indicate whether it was AM or PM by circling the appropriate indicator.

Where programs are consolidated as a behavioral health effort, this field should be used to identify the **primary** source of funding used to support the provider. The **OTHER** field is used to identify providers using this system who are not supported directly by either of these funding sources.

Clinic is the type of clinic taking place. The App't/Walk-in field should be self-explanatory.

3. **Problem List Update**

To change the status of existing problems, use the boxes at the top of the page in conjunction with the patient's current Health Summary. A problem may be removed or its status changed to active or inactive by entering the problem number (from the Health Summary) in the appropriate box. A removed problem is actually deleted from the system and not available for future retrieval purposes. Remember that use of these fields only effects the Problem List in the MH/SS Data File. Changes in the Problem List in PCC require use of the PCC input document. In either case these changes should only be made using a current copy of the patient's health summary.

4. **Provider(s) Code**

Provider codes consist of an affiliation code, a discipline code, and a code for the given individual, usually the person's initials. The providers at each location should work with their Site Manager, and the Area System Manager to develop the individual provider identifications to be used.

The form has provisions for identifying more than one provider involved in the activity, with the last line identified for the **primary** provider. The primary provider is the individual who will ultimately sign the form. Secondary or other providers should **not** be MH/SS staff who will be expected to report this activity as well.

Flag A ten-digit undefined code field for local use.

In addition to identifying all the providers involved in the reported contact, **Designated Providers** can be identified for specific patients.

Programs who wish to use this feature should make sure that all staff are aware of how the designation is being used.

The boxes in the upper left hand corner of the form can be used to specify a Designated Provider. This information will be added to the Patient's File and shown on the MH/SS Health Summary, consequently it is not necessary to use this feature on each visit.

To change Designated Provider simply submit a record identifying the new Designated Provider.

5. **Open/Admit/Close**

Check appropriate Box to add action on this date. Information is treated as visit related and added to patient's record.

OPEN- First contact for this episode of this illness for this patient.

ADMIT- Begin agreed-upon treatment. Treatment plan may or may not be in place.

CLOSE- Treatment for this episode of illness discontinued.

DISPOSITION- Enter disposition codes when Case is Closed.

1- Completed Treatment, Stable	5- Pt. Dropped out
2- Referred to Other Source	6- Pt. Moved
3- Mutual Agreement to Terminate	7- Pt. Died
4- Administrative Termination	8- Other

6. **Community**

Identifies location where reported activity took place. Use Standard IHS State-County-Community codes. Just remember that **all** IHS Facilities are located **IN** an identifiable community.

7. **Activity**

Use MH/SS Activities Code list to identify appropriate activity being reported. Note that travel is a reportable activity. Travel time can be lumped for reporting on a single form, once for each day.

Record only **ONE** Activity code on each record. Use the one that best describes the major activity.

8. **Number Served**

Whole number from 1-999 describing number receiving services from this activity. For most direct patient care this will be only 1, but for a variety of other activities it will probably be more than 1. For some administrative activities the number served will only be the reporter.

9. **Activity/Service Time**

Record the amount of time, in minutes from 1-999, that the reported activity took.

10. **Type of Contact**

Check the appropriate box to identify the type of contact this activity involved. If **Outpatient** is checked, then the arrival time field must be filled in as well. 'Type of Contact' is an important field since it is one of the fields used to determine whether a PCC visit is generated from the MH/SS record.

11. **Chief Complaint, Subjective/Objective**

This section is used to record narrative information on the nature of the activity being reported.

For direct patient care this should include the narrative history, physical examination and progress notes, and/or the subjective/objective observations of the provider. If more space is needed to record information the back side of the first page (white copy) can be used, or notes may be written on a suitable continuation sheet that can be added to the health record.

Where confidential information is to be recorded, information which should not appear on the data entry and referral copies of the form, it should be recorded on the back of the white copy or on a continuation sheet.

Data entry staff will not review this section of the form for entry of any data, so any information that is intended to go into the MH/SS Data File and/or PCC must be recorded in other appropriate sections of the form.

When in Use, the **INTERPRETER REQUIRED** box should only be checked when there is a specific need for this service and should **NOT** be used as a substitute for recording effort where the secondary provider is considered as a co-therapist.

12. **Purpose of Visit**

The MH/SS module is organized to simplify the data entry process by asking the provider to clearly communicate the nature of the contact. Providers are asked to code and describe the nature of the problem with a brief narrative. This is the most important section of the Record.

Every Encounter form submitted for data entry **MUST** have at least one Purpose of Visit identified. This field is used to determine whether a PCC visit is to be generated; to update a patient's file; to create or update a patient's problem list, (discussed in more detail in the next section), and/or to specify activities workload for providers. Speed and accuracy of data entry are totally dependent on ability to read and understand information recorded in this section. Legibility in this section of the form is critical. Users, are therefore, required to print in this section of the Record.

Purpose of Visit must include both a POV Code and a brief narrative description of the problem.

POV Codes

Use either the one or two digit MH/SS Purpose of Visit Codes or the more specific five digit DSM-III-R Diagnostic codes. Please Do Not use the V-Codes as a purpose of visit code.

The choice of which code is used will in many instances govern what information is, or is not, passed to PCC so some attention to these issues is required. See the Purpose of Visit Codes discussion for an overview of this process.

POV Narrative

For each POV Code, the provider should add a brief description of the problem being addressed. This may be as simple as the problem label, e.g., "Marital Problem" or a more detailed narrative statement. When a DSM-III-R Diagnosis is used as a POV, the narrative, as written by the provider, will be passed to the PCC. When a MH/SS Problem Code is used as a POV the set-up option chosen by the program will govern what is passed to the PCC (e.g., in Option 3, the narrative shown accompanying the ICD-9-CM diagnostic code on the attached MH/SS to ICD-9-CM crosswalk will be passed as the narrative.)

Where there are multiple purposes of visit, each one should be recorded on a separate line with the primary reason for the visit on the first line. Do not attempt to list everything in this section, limit your description to conditions being dealt with, or directly relevant to, the issue at hand.

Note that an attempt has been made to address the special cases, medications/medications monitoring (with or without the patient being present), chart reviews, telephone contacts, and no-shows by either using specific activity codes, checking specific Type of Contact or using particular POV codes.

13. **Problem List**

The Purpose of Visit section has fields which can be used to ADD problems to the problem list of either the PCC or the MH/SS data files, or both.

Generally, the purpose of the problem list is to note current or historical issues that may be of importance to other providers in their care of a specific patient. In this system problems are characterized as active or inactive. Active problems are differentiated from inactive problems by their direct clinical significance.

Active problems are those that are currently affecting the patient's health, or if presently quiescent, are at high risk of recurrence.

Inactive problems are defined as problems that have been resolved but which may recur in the future. These recurring problems may place the patient at increased risk, or may have left residual physical or mental concerns.

It is not necessary, or appropriate, to add all purposes of visit to the patient's problem list. The purposes of visit recorded for the most recent visits will be displayed in Outpatient Section of the Health Summary (PCC--Maximum of 5 Visits or 1 year; MH/SS--Maximum of 10 visits or 2 years), but only selected ones should be added to the problem list. **Appendix 2 in the PCC Manual describes the appropriate contents of a problem list.**

When a diagnosis or a problem is considered to be of sufficient importance as to be communicated to other providers using the problem list(s), the reporter must decide if the problem should be added to the PCC Problem list, i.e., called to the attention of all clinical users of the system, or just to the MH/SS Problem List, i.e., just called to the attention of MH/SS users of the system, or both.

Usually, a provider is interested in adding only the current problem to the problem list, however, issues that probably should be added to the problem list may come to the providers attention and they can be added, either as active or inactive problems, as well.

Problems can be added, modified (i.e., status changed from 'active' to 'inactive', or vice versa, information about the problem added or deleted), or removed from the problem list of the MH/SS file using the MH/SS Encounter Record. They can only be **added** to the PCC data file using this record, any other manipulation of that problem list requires the use of a PCC Ambulatory Encounter form.

Additions and changes to the problem list should be made only with a copy of the most recent Health Summary in hand.

Adding a Problem to the PCC Problem List

With two exceptions, **ONLY** problems identified with a DSM/ICD-9-CM Diagnosis can be added to the PCC Problem List.

Checking the first column in the Purpose of Visit Section will ensure that this problem (identified by the ICD-9-CM Diagnosis label), along with the narrative text the provider has included, will be added to the PCC Problem List, and will be included in any health summaries generated for that patient.

The **TWO Exceptions** to the restriction that the problem be coded with a DSM/ICD-9-CM Diagnosis before it can be added to the PCC Problem List are the MH/SS Problem Codes for "Suicide Ideation" and "Suicide Attempt/Gesture". MH/SS Problem Codes 39 and 40. **These two problems should ALWAYS be added to the PCC Problem List.**

Please add a **Date of Onset** in the narrative field for any problems you want to add to the PCC Problem List.

The MH/SS input record can only be used to **add** problems to the PCC Problem List and these should only be current, and active problems. Changes to the PCC Problem List, i.e., modifications, removal or moving to inactive, can only be carried out by using a PCC Ambulatory Encounter Form.

The Problem Lists shown in the Health Summary integrates data from both the PCC and MH/SS data files. Adding a problem to the PCC Problem List will not ensure that the problem is also added to the MH/SS Problem List. That is a separate operation.

Adding Problems to the MH/SS Problem List

Adding Active Problems. By checking the second column in the Purpose of Visit Section of the Record, **any** purpose of visit code, DSM Diagnosis or 1 or 2 digit MH/SS Problem Code, can be added to the MH/SS Problem List **as an Active Problem**. The problem, as coded by the provider, along with the provider Narrative will be added to the MH/SS Problem List.

Generally **ANY** problem added to the PCC Problem List **should** be added to the MH/SS Problem List as well, but since there may be exceptions, the provider must indicate this on the form in the second column.

MH/SS Problem Codes 39 "**Suicide Ideation**" and 40 "**Suicide Attempt/Gesture**" should **ALWAYS** be added to the MH/SS problem list just as they are to the PCC problem list.

Data entry assumes that **any** problem which is checked to be added to the MH/SS Problem List is **Active** unless otherwise noted.

Please note a **Date of Onset** in the narrative field when adding a problem to the MH/SS Problems List.

Adding Inactive Problems. To identify an **Inactive** problem that you wish to add to the Problem List, simply **Add** the Letter **I** after the check mark in the second column of the Purpose of Visit Section of the input record.

Changing the Status of Existing Problems

The boxes at the top center of the Encounter Record are used in conjunction with a copy of the patient's current MH/SS Health Summary, to change the status of or remove an existing problem. To make these changes enter the identification number of the problem, as shown on the health summary, in the appropriate box on the form. Note that a 'removed' problem is actually deleted from the system and will not be available for future retrieval purposes.

Medical Problem Narrative

For those situations where providers (mainly Psychiatrists) are treating **other** non-psychiatric conditions, any treatment that should be added to the PCC file for this patient can be recorded here.

14. **Treatment Note(s)**

Providers can link and record **both** short and long term treatment notes with identified problems using the Problem #, STP and LTP fields in the Treatment Note Narrative Section of the Encounter Record.

Adding Treatment Note(s)

To add a treatment note enter the problem # (either from the list of problems you have just identified in the Purpose of Visit Field above, or from the MH/SS Health Summary) in the first portion of the Treatment Note Field, then specify whether this is a **Short Range Treatment Plan-STP** or a **Long Range Treatment Plan-LTP** by checking the appropriate box, then add the narrative in the next field.

Modifying a Treatment Note(s)

To modify a treatment note preface the Problem # field with the letter **C** (to indicate a **CHANGE**) and indicate the changes by filling in the appropriate fields, STP, LTP, Narrative with the new information.

Removing a Treatment Note(s)

Use the "**Remove Note**" field to identify the note you wish to remove. Simply note the Problem # from the MH/SS Health Summary.

Note that as with removing Problems from the Problem list, when a Treatment Note is "removed" it is deleted and no longer available as a piece of information about this patient.

15. **Medications Prescribed this Visit**

The provider records the medications ordered here for use by the pharmacist.

Prescriptions will be coded and added to the PCC, but not the MH/SS data file, from the Pharmacy System. Prescriptions written by MH/SS staff that will not be filled by the IHS should be recorded under Treatment Note, above.

16. **Psychosocial Problems- AXIS IV, and Functional Level- AXIS V**

For all direct patient care reporting identify major Psychosocial or Environmental Problem for Axis IV. Use MH/SS Problem Codes to amplify or expand. Use 0-100 scale to report Current Functional Level AXIS V. Each should be recorded at each visit.

17. **Inpatient Disposition**

Used only to record information on commitment of patient to treatment resource. Use appropriate code to specify facility type and enter facility name.

18. **Level of Service Code**

Not in use at this time.

19. **Personal History**

Check appropriate boxes. This data will be added to the patient's history file, so once it is entered it is not necessary to repeat this addition each visit. It will show up on the Patient's MH/SS Health Summary.

20. **PROCEDURE CODE(S)**

Use CPT codes as appropriate to indicate what was done.

21. **Comment**

Word Processing Field to record Reporter's comments on patient, patient's care, activity, etc.

22. **Referral/Patient Instructions**

The lower section of the record is used to indicate future appointments and/or to provide instructions to other providers as well as the patient. The yellow copies of the form are available to be given to the patient, if appropriate, or to other health care providers as a referral note.

23. **Provider Signature**

The form is the legal record of services provided and, as such, must be signed by the primary provider of care.

Activity Codes and Definitions

The Mental Health/Social Services activity codes are presented here by category for ease in reviewing and locating particular codes. The category labels are for organizational purposes only and cannot be used alone to report activities; however, aggregate reports can be organized by these activity categories.

All the Activity Codes shown with a three letter acronym are assumed to involve services to a specific patient. During the data entry process, if you enter one of these activity codes, you must also enter the patient's name so that the data you enter can be added to the patient's visit file.

Patient Services (Patient Always Present)

Direct services provided to a specific person (client/patient) to diagnose and prognosticate (describe, predict, and explain) the recipient's mental health status relative to a disabling condition or problem; and where indicated to treat and/or rehabilitate the recipient to restore, maintain, or increase adaptive functioning. **Always** involves face-to-face contact with the client/patient. Includes:

- **11- SCN Screening**
Services provided to determine in a preliminary way the nature and extent of the recipient's problem in order to link him/her to the most appropriate and available resource.
- **12- EVL Assessment/Evaluation**
Formal assessment activities intended to define or delineate the client/patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.
- **13- IND Individual Treatment/Counseling/Education**
Prescribed services with specific goals based on diagnosis and designed to arrest, reverse, or ameliorate the client/patient's disease or problem. The recipient in this case is an individual.
- **14- FAM Family/Group Treatment**
Same definition as 13 above, but the referent and process are focused on the family or a group of patients.
- **15- REF Information and/or Referral**
Provision of information to help others understand the condition of the client and to assist in the decision-making process in his/her care and/or to arrange for transfer of the client/patient to another caregiver or part of the treatment system.

- **16- MED Medication/Medication Monitoring**
Review of the client/patient's treatment progress focusing on medication regimen.
- **17- TST Psychological Testing**
Examination and assessment of client/patient's status through the use of standardized psychological, educational, or other evaluative test. Care must be exercised to assure that the interpretations of results from such testing are consistent with the socio-cultural milieu of the client/patient.
- **18- FOR Forensic Activities**
Address any of the specific forensic needs of a specific client/patient.
- **19- DSG Discharge Planning**
Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.
- **20- FAC Family Facilitation**
Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.
- **21- FOL Follow-through/Follow-up**
Periodic evaluative review of a specific client/patient's progress after discharge.
- **22- CAS Case Management**
Activities involved in the systematic management of the system of care for a specific patient. May or may not be separate from treatment functions. Advocacy and “brokering” to assure continuity of quality care based on a treatment plan that attempts to maximize access to and effective use of available services.
- **23- OTH Other Patient Services not identified here**
Any other patient services not identified in this list of codes.
- **48- CIP Crisis Intervention**
Any activities directly involved with crisis intervention for a specific patient.

Support Services (Patient Not Present)

Indirect services (e.g., information gathering, service planning, and collaborative efforts) undertaken to support the effective and efficient delivery or acquisition of services for specific clients/patients. These services, by definition, do not involve direct recipient contact. Includes:

- **24- SUP Material/Basic Support**
Support services required to meet the generic needs of the client/patient for food, shelter, and safety.
- **25- INF Information and/or Referral**
Provision of information to relevant others to help them understand the client's condition and to assist in the decision-making process in his/her care and/or to arrange for transfer of the client/patient to another caregiver or part of the treatment system.
- **26- MEA Medication/Medication Monitoring**
Review of the client/patient's treatment progress focusing on medication regimen.
- **27- FOA Forensic Activities**
Address any of the specific forensic needs of a specific client/patient.
- **28- DSA Discharge Planning**
Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.
- **29- FAA Family Facilitation**
Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention
- **30- FUA Follow-up/Follow-through**
Periodic evaluative review of a specific client/patient's progress after discharge.
- **31- CAA Case Management**
Activities involved in the systematic management of the system of care for a specific patient. May or may not be separate from treatment functions. Advocacy and "brokering" to assure continuity of quality care based on a treatment plan that attempts to maximize access to and effective use of available services.
- **32- Clinical Supervision**
Supervision of clinical services.
- **33- Technical Assistance**
Task-specific assistance to achieve an identified end.

- **34- Other Support Services**
Any other ancillary, adjunctive, or collateral services not identified here.
- **40- Referral**
Activities associated with referral of a patient/client where no information is added to the patient/client's file.
- **44- Screening**
Activities associated with patient/client screening where no information is added to the patient/client's file.
- **45- Assessment/Evaluation**
Assessment or evaluation activities where no information is added to the patient/client's file.
- **46- Family/Group**
Activities involving families or groups where no information is added to a patient/client's file.
- **49- CIA Crisis Intervention**
Activities involved with crisis intervention on behalf of a specific patient when the patient is not present.

Community Services

Assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems. Includes:

- **35- Collaboration**
Collaborative effort with other agency or agencies to address a community request.
- **36- Community Development**
Planning and development efforts focused on identifying community issues and methods of addressing these needs.
- **37- Preventive Services**
- **38- Patient Transport**
- **39- Other Community Services**
Any other form of community services not identified here.

Education/Training

Participation in any formal program leading to a degree or certificate or any structured educational process designed to impart job-related knowledge, attitudes and skills. Includes:

- 41- Education/Training Provided
- 42- Education/Training Received
- 43- Other Education/Training

Crisis Intervention

- **48- CIP Crisis Intervention (Patient Present)**

Crisis intervention involving a specific patient where the patient is present.

- **49- CIA Crisis Intervention (Patient Not Present)**

Crisis intervention involving a specific patient where the patient is not present.

Administration

Activities for the benefit of the organization and/or activities that do not fit into any of the above categories. Includes:

- 50- Medical Rounds (General)
- 51- Committee Work
- 52- Surveys/Research
- 53- Program Management
- 54- Quality Improvement
- 55- Supervision
- 56- Records/Documentation
- 57- Child Protective Team Activities
- 58- Special Projects
- 59- Other Administrative
- 60- Case Staffing (General)

Consultation

Problem-oriented effort designed to impart knowledge, increase understanding and insight, and/or modify attitudes to facilitate problem resolution. Includes:

- **61- PRO Provider Consultation**

Focus is a specific patient and the consultation is with another service provider. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

- **62- CHT Patient Consultation (Chart Review Only)**

Chart review only.

- **63- Program Consultation**

Focus is a programmatic effort to address specific needs.

- **64- Staff Consultation**

Focus is a provider or group of providers addressing a type or class of problems.

- **65- Community Consultation**

Focus is a community effort to address problems. Distinguished from community development in that the consultant is not assumed to be a direct part of the resultant effort.

Travel

- 71- Travel Related to Patient Care
- 72- Travel **Not** Related to Patient Care

Placements

- 75- OHP Placement (Patient Present)
- 76- OHA Placement (Patient **Not** Present)
- 77- Out of Home Placement

Cultural Issues

- **81- TRD Traditional Specialist Consult (Patient Present)**

Seeking recommendation or service from a recognized Indian spiritual leader or Indian doctor with the patient present. Such specialists may be called in either as advisors or as direct providers, when agreed upon between client and counselor.

- **82- TRA Traditional Specialist Consult (Patient Not Present)**

Seeking evaluation, recommendations, or service from a recognized Indian spiritual healer or Indian doctor (patient not present). Such specialists may be called in either as advisors or as direct providers, when agreed upon between client and counselor.

- **83- Tribal Functions**

Services offered during or in the context of a traditional tribal event, function, or affair—secular or religious. Community members gather to help and support individuals and families in need.

- **84- Cultural Education to Non-Tribal Agency/Personnel**

The education of non-Indian service providers concerning tribal culture, values, and practices. This service attempts to reduce the barriers members face in seeking services.

Purpose of Visit Codes

The purpose of visit codes are listed here by category for conceptual clarity only. These categories cannot be used to report activities; however, they can be used to summarize information in reports.

The following tables show the ICD Code (shown in the parentheses) that is passed to the PCC when that MH/SS problem code is used as a purpose of visit (POV). Codes marked with the asterisk (*) will have the phrase “See (**Provider's Name**) for details of this problem” appended to the narrative that is passed to the PCC. Codes marked with a bullet (•) will have the phrase “Diagnostic Impression” prefaced to the information passed to the PCC. See the Setting Site Parameters section of this manual for other options that may be used for passing information to the PCC.

In the Definitions section of the POV codes, note that the Psychosocial Problems category includes the full range of DSM-IV diagnostic codes. The V-codes shown are ICD V Codes. **Do not** use the DSM-IV V-Codes or ICD V Codes for POVs.

In the tables below, the problem code is presented first, followed by the narrative and ICD-9 code.

Medical/Social Problems Category

1	Health/Homemaker Needs	(V60.4)
2	Cross-Cultural Issue	(V62.9) *
3	Unspecified Mental Disorder	(V40.9) *
4	Physical Disability/Rehabilitation	(V57.9)
5	Physical Illness, Acute	(V15.89)
6	Physical Illness, Chronic/Terminal	(V15.89)
7	Non-Compliance w/Treatment Regimen	(V15.81)
8	Failed Appointments, No Show	(V15.81)

Psychosocial Problems Category

NOTE: In addition to the full range of DSM-IV diagnostic codes, use the following problem codes as problem descriptions. When you use these problem codes, the ICD-9 code shown in parentheses is passed to the PCC (using the IHS Standard Crosswalk in Option 3) prefaced by the phrase "Diagnostic Impression."

Organic Mental Disorders

9	Senile and Pre-Senile Condition	(290.0)
10	Alcohol Withdrawal Delirium	(291.0)
11	Drug Withdrawal Syndrome	(292.0) •
12	Other Organic Mental Disorder/Nos	(294.8) •

Other Psychoses

13	Schizophrenic Disorder	(295.90) •
14	Major Depressive Disorder	(311) •
15	Bipolar Disorder	(296.7) •
16	Delusional Disorder	(297.1) •
17	Psychotic Disorder Nec	(298.9) •

Neurotic, Personality and Other Nonpsychotic Disorders

18	Anxiety Disorder	(300.00) •
19	Personality Disorder	(301.9) •
20	Psychosexual Disorder	(302.9) •
21	Special Symptom Nec	(307.9) •
21.1	Medication-Induced Disorder	(995.2) •
22	Sleep Disorder	(307.47) •
23	Eating Disorder	(307.50) •
24	Adjustment Disorder	(309.9) •
25	Disruptive Behavior Disorder	(312.9) •
26	Impulse Control Disorder	(312.30) •

Alcohol and Drug Abuse

27	Alcohol Dependence	(303.90) ●
28	Drug Dependence	(304.90) ●
29	Alcohol Abuse	(305.00) ●
30	Drug Abuse	(305.90) ●

Disorders First Evident in Infancy, Childhood, or Adolescence

31	Disorder of Infancy, Childhood/Adol.	(313.9) ●
32	Pervasive Developmental Disorder	(299.81) ●
33	Mild Mental Retardation	(317) ●
34	Moderate to Profound Mental Retardation	(318.0) ●
35	Unspecified Mental Retardation	(319) ●

Other

36	Psychic Factors Associated with Disease	(316) ●
37	Factitious Disorder	(300.19) ●
38	Other Suspected Mental Condition	(V71.09)
38.1	Diagnosis Deferred, Axis I or Axis II	(799.9)

Suicide

39	Suicide (Ideation)	(300.9)
40	Suicide (Attempt/Gesture)	(300.9)
41	Suicide (Completed)	(798.1) *

Abuse Category

Child Abuse (Victim)

995.50	“...Provider Narrative...”	(995.50)
42	Child Abuse (Suspected), Unspecified	(995.50)
995.54	Physical Abuse of Child (Victim)	(995.54)
42.1	Child Abuse (Suspected), Physical	(V15.49) *
42.2	Child Abuse (Suspected), Emotional	(V15.49) *
995.53	Sexual Abuse Of Child (Victim)	(995.53)
42.3	Child Abuse (Suspected), Sexual	(V15.49) *

Partner Abuse (Victim)

43	Partner Abuse (Suspected), Unspecified	(995.80)
43.1	Partner Abuse (Suspected), Physical	(V15.49) *
43.2	Partner Abuse (Suspected), Emotional	(V15.49) *
43.3	Partner Abuse (Suspected), Sexual	(V15.49) *

Adult Abuse (Victim)

995.80	"...Provider Narrative ..."	(995.80)
44	Adult Abuse (Suspected), Unspecified	(995.80)
44.1	Adult Abuse (Suspected), Physical	(V15.49) *
44.2	Adult Abuse (Suspected), Emotional	(V15.49) *
44.3	Adult Abuse (Suspected), Sexual	(V15.49) *

Child/Partner/Adult Abuse (Perpetrator)

45	Abusive Behavior (Alleged), Unspec.	(V15.49) *
45.1	Abusive Behavior (Alleged), Physic.	(V15.49) *
45.2	Abusive Behavior (Alleged), Emotio.	(V15.49) *
45.3	Abusive Behavior (Alleged), Sexual,	(V15.49) *

Rape

46	Rape (Alleged/Suspected)	(V71.5)
46.1	Rape (Alleged/Perpetrator)	(V71.5)
46.2	Incest Survivor (Alleged)	(V15.49) *

Neglect Category

995.52	Neglect of Child (Victim)	(995.52)
47	Child Neglect (Suspected)	(V61.29)
48	Adult Neglect (Suspected)	(995.81)
49	Partner Neglect (Suspected)	(995.81)

Family Life Problems Category

51	Alcohol Related Birth Defect Arbd	(V13.7) *
51.1	Fetal Alcohol Syndrome Fas	(760.71)
52	Child Or Adolescent Antisocial Behavior	(V71.02)
53	Adult/Child Relationship	(V61.20)
54	Uncomplicated Grief Reaction	(V62.82)
54.1	Death	(V68.89)
54.2	Dying	(V62.89)
55	Illness in Family	(V61.49)
56	Marital Problem	(V61.10)
57	Sibling Conflict	(V61.8)
58	Separation/Divorce	(V61.0)
59	Family Conflict	(V61.8)
60	Interpersonal Relationship	(V62.81)
61	Adult Antisocial Behavior	(V71.01)
62	Other Family Life Problem	(V62.89)

Pregnancy/Childbirth Problems Category

63	Pregnancy Conflict	(V61.8) *
64	Adoption	(V68.89) *
65	Family Planning	(V26.4)
66	Pregnancy Concerns	(V61.8) *
67	Teenage Pregnancy	(V61.8) *
68	High Risk Pregnancy	(V23.9)
69	Other Childbearing Problems	(V61.8) *

Socioeconomic Problems Category

78	Alternate Health Resources	(V68.89)
79	Financial Needs/Assistance	(V60.2)
79.1	Inadequate Personal Resources	(V61.9)
79.2	Inadequate Access to Resources	(V63.0)
80	Housing	(V60.1)
81	Nutrition	(V65.3)
82	Employment	(V62.0)
83	Transportation	(V60.8)
84	Co-Worker Difficulties	(V62.2)
85	Other Socioeconomic Problems	(V60.8)

Sociolegal Problems Category

86	Forensic: Criminal	(V62.5)
87	Forensic: Civil	(V62.5)
88	Other Sociolegal Problems	(V62.5)

Educational/Life Problems Category

89	Academic Problem	(V62.3)
90	School Behavior Problem	(V40.3)
91	School Dropout	(V62.3)
92	Vocational Rehabilitation	(V57.2)
93	Peer Conflict	(V62.81)
94	Phase of Life Problem	(V62.89)

Administrative Problems Category

95	Continuing Education	(V65.40)
96	Training Needs	(V65.49)
97	Administration	(V68.9)
98	Employee Assistance Program	(V65.49)
99	Other Administrative Problems	(V68.9)

Definitions for Purpose of Visit Codes

The Psychosocial Problems category includes the full range of DSM-IV diagnostic codes. The V-codes shown are ICD V Codes. **Do not** use the DSM-IV V-Codes or ICD V Codes for POVs.

Medical/Social Problems Category

- 1-(V60.4)** Health/Homemaker Needs - Problems associated with monitoring the patient and providing care in the home.
- 2-*(V62.9)** Cross-Cultural Issue - Problems which arise from cultural beliefs or experience. Concerns expressed in traditional or cultural terms/ways.
- 3-*(V40.9)** Unspecified Mental Problem - Problems which for the time being cannot be completely specified in clear diagnostic terms.
- 4-(V57.9)** Physical Disability/Rehabilitation - Problems of physical restoration and social and emotional adjustment to physical disability.
- 5-(V15.89)** Physical Illness, Acute - Social and emotional adjustment problems associated with acute illness.
- 6-(V15.89)** Physical Illness, Chronic/Terminal - Social and emotional problems associated with long-term, or terminal illness and the care associated with these states.
- 7-(V15.81)** Noncompliance with Treatment Regimen - Noncompliance that is apparently not due to mental disorder.
- 8-(V15.81)** Failed Appointments/No Show - Missed appointments by patients.

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

Psychosocial Problems Category

Organic Mental Disorders

Senile and Presenile Condition

- 9- 290.0● Dementia, Alzheimer's Type, W/Late Onset, Uncomp.
290.10 Dementia, Alzheimer's Type, W/Early Onset, Uncomp.
Dementia Due to Cruetzfeldt-Jacob Disease,
Dementia Due to Pick's Disease
290.11 Dementia, Alzheimer's Type, W/Early Onset, W/Delirium
290.12 Dementia, Alzheimer's Type, W/Early Onset, W/Delusions
290.13 Dementia, Alzheimer's Type, W/Early Onset, W/Depression
290.20 Dementia, Alzheimer's Type, W/Late Onset, W/Delusion
290.21 Dementia, Alzheimer's Type, W/Late Onset, W/Depressed Mood
290.3 Dementia, Alzheimer's Type, W/Late Onset, W/Delirium
290.40 Vascular Dementia, Uncomplicated
290.41 Vascular Dementia, W/Delirium
290.42 Vascular Dementia, W/Delusions
290.43 Vascular Dementia, W/Depressed Mood

Alcoholic Withdrawal Delirium

- 10- 291.0● Alcohol Intoxication Delirium
Alcohol Withdrawal Delirium
291.1 Alcohol-Induced Persisting Amnestic Disorder
291.2 Alcohol-Induced Persisting Dementia
291.3 Alcohol-Induced Psychotic Disorder, With Hallucin.
291.5 Alcohol-Induced Psychotic Disorder, With Delusions
291.81 Alcohol Withdrawal
291.89 Alcohol-Induced Mood Disorder
(Alcohol-Induced Mood Disorder, Anxiety,
Sexual Dysfunction, or Sleep Disorder)
291.9 Alcohol-Related Disorder NOS

Drug Withdrawal Syndrome

- 11- 292.0● Drug Withdrawal,
Amphetamine, Cocaine, Nicotine, Opioid,
Other (or Unknown) Substance, Sedative,
Hypnotic or Anxiolytic Withdrawal

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- 292.11 Drug-Induced Psychotic Disorder, W/Delusions
Amphetamine-, Cannabis-, Cocaine-, Hallucinogen-,
Inhalant-, Opioid-, Other (or Unknown) Substance-,
Phencyclidine-, Sedative-, Hypnotic-, or Anxiolytic-
Induced Disorder, With Delusions
- 292.12 Drug-Induced Psychotic Disorder, W/Hallucinations
Amphetamine-, Cannabis-, Cocaine-, Hallucinogen-,
Inhalant-, Opioid-, Other (or Unknown) Substance-,
Phencyclidine-, Sedative-, Hypnotic-, or Anxiolytic-
Induced Disorder, With Hallucinations
- 292.81 Drug-Induced Delirium
Amphetamine-, Cannabis-, Cocaine-, Hallucinogen-,
Inhalant-, Opioid-, Other (or Unknown) Substance-,
Phencyclidine-, Sedative-, Hypnotic-, or Anxiolytic-
Intoxication Delirium
- 292.82 Drug-Induced Persisting Dementia
Inhalant-, Other (or Unknown) Substance-, Sedative-,
Hypnotic-, or Anxiolytic-Induced Persisting Dementia
- 292.83 Drug-Induced Persisting Amnestic Disorder
Other (or Unknown) Substance-, Sedative-, Hypnotic-,
or Anxiolytic-, Induced Amnestic Disorder
- 292.84 Drug-Induced Mood Disorder
Amphetamine-, Cocaine-, Hallucinogen-, Inhalant-,
Opioid-, Other (or Unknown) Substance-, Phencyclidine-
Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
- 292.89 Other Specified Drug-Induced Intoxication or Induced
Mental Disorders
Amphetamine-, Caffeine-, Cannabis-, Cocaine-,
Hallucinogenic-, Inhalant-, Other (and Unknown)-
Phencyclidine-, Sedative-, Hypnotic-, or Anxiolytic-
Intoxication, or Induced Anxiety Disorder, Sexual
Dysfunction, or Sleep Disorder,

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- 292.9 Unspecified Drug-Related Disorder NOS
Amphetamine-,Caffeine-, Cannabis-, Cocaine-,
Hallucinogenic-, Inhalant-, Nicotine-, Opioid-
Other (or Unknown) Substance-, Phencyclidine-, Sedative-,
Hypnotic-, or Anxiolytic-Related Disorders NOS

Other Organic Mental Disorder NOS

- 293.0 Delirium Due to...(Indicate Med. Condition)
293.81 Psychotic Disorder Due to...(Indicate Med.Cond.), W/Delusions
293.82 Psychotic Disorder Due to...(Indicate Med.Cond.), W/Hallucin.
293.83 Mood Disorder Due to...(Indicate Med. Condition)
293.84 Anxiety Disorder Due to...(Indicate Med. Condition)
293.9 Mental Disorder NOS Due to...(Indicate Med. Condition)
294.0 Amnestic Disorder Due to...(Indicate Med. Condition)
294.1 Dementia Due to...(Indicate Medical Condition)
12- 294.8● Amnestic Disorder or Dementia NOS

Other Psychoses

Schizophrenic Disorder

- 295.10 Schizophrenia, Disorganized Type, Unspecified
295.11 Schizophrenia, Disorganized Type, Subchronic
295.12 Schizophrenia, Disorganized Type, Chronic
295.13 Schizophrenia, Disorganized Type, Subchronic W/Acute Exacerbation
295.14 Schizophrenia, Disorganized Type, Chronic W/Acute Exacerbation
295.15 Schizophrenia, Disorganized Type, In Remission
295.20 Schizophrenia, Catatonic Type, Unspecified
295.21 Schizophrenia, Catatonic Type, Subchronic
295.22 Schizophrenia, Catatonic Type, Chronic
295.23 Schizophrenia, Catatonic Type, Subchronic, W/Acute Exacerbation
295.24 Schizophrenia, Catatonic Type, Chronic, W/Acute Exacerbation
295.25 Schizophrenia, Catatonic Type, In Remission
295.30 Schizophrenia, Paranoid Type, Unspecified
295.31 Schizophrenia, Paranoid Type, Subchronic
295.32 Schizophrenia, Paranoid Type, Chronic
295.33 Schizophrenia, Paranoid Type, Subchronic, W/Acute Exacerbation
295.34 Schizophrenia, Paranoid Type, Chronic, W/Acute Exacerbation
295.35 Schizophrenia, Paranoid Type, In Remission
295.60 Schizophrenia, Residual Type, Unspecified
295.61 Schizophrenia, Residual Type, Subchronic

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- 295.62 Schizophrenia, Residual Type, Chronic
- 295.63 Schizophrenia, Residual Type, Subchronic, W/Acute Exacerbation
- 295.64 Schizophrenia, Residual Type, Chronic, W/Acute Exacerbation
- 295.65 Schizophrenia, Residual Type, In Remission

- 13- 295.90●Schizophrenia, Undifferentiated Type, Unspecified
- 295.91 Schizophrenia, Undifferentiated Type, Subchronic
- 295.92 Schizophrenia, Undifferentiated Type, Chronic
- 295.93 Schizophrenia, Undifferentiated Type, Subchronic, W/Acute Exacerbation
- 295.94 Schizophrenia, Undifferentiated Type, Chronic, W/Acute Exacerbation
- 295.95 Schizophrenia, Undifferentiated Type, In Remission

Major Depressive Disorder

- 300.4 Dysthymic Disorder

- 14- 311● Depressive Disorder NOS

- 296.20 Major Depressive Disorder, Single Episode, Unspecified
- 296.21 Major Depressive Disorder, Single Episode, Mild
- 296.22 Major Depressive Disorder, Single Episode, Moderate
- 296.23 Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
- 296.24 Major Depressive Disorder, Single Episode, Severe With Psychotic Features
- 296.25 Major Depressive Disorder, Single Episode, In Partial Remission
- 296.26 Major Depressive Disorder, Single Episode, In Full Remission
- 296.30 Major Depressive Disorder, Recurrent, Unspecified
- 296.31 Major Depressive Disorder, Recurrent, Mild
- 296.32 Major Depressive Disorder, Recurrent, Moderate
- 296.33 Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
- 296.34 Major Depressive Disorder, Recurrent, Severe With Psychotic Features
- 296.35 Major Depressive Disorder, Recurrent, In Partial Remission
- 296.36 Major Depressive Disorder, Recurrent, In Full Remission

Bipolar Disorder

- 296.00 Bipolar I Disorder, Single Manic Episode, Unspecified
- 296.01 Bipolar I Disorder, Single Manic Episode, Mild
- 296.02 Bipolar I Disorder, Single Manic Episode, Moderate
- 296.03 Bipolar I Disorder, Single Manic Episode, Severe, Without Psychotic Features

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- 296.04 Bipolar I Disorder, Single Manic Episode, Severe, with Psychotic Features
- 296.05 Bipolar I Disorder, Single Manic Episode, In Partial Remission
- 296.06 Bipolar I Disorder, Single Manic Episode, In Full Remission
- 296.40 Bipolar I Disorder, Most Recent Episode Manic or Hypomanic, Unspecified
- 296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild
- 296.45 Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
- 296.46 Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
- 296.50 Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
- 296.51 Bipolar I Disorder, Most Recent Episode Depressed, Mild
- 296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate
- 296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe, Without Psychotic Features
- 296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe, With Psychotic Features
- 296.55 Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
- 296.56 Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
- 296.60 Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
- 296.61 Bipolar I Disorder, Most Recent Episode Mixed, Mild
- 296.62 Bipolar I Disorder, Most Recent Episode Mixed, Moderate
- 296.63 Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
- 296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe, With Psychotic Features
- 296.65 Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
- 296.66 Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission

- 15- 296.7● Bipolar I Disorder, Most Recent Episode Unspecified,
- 296.80 Bipolar Disorder NOS
- 296.89 Bipolar II Disorder
- 296.90 Mood Disorder NOS

- 301.13 Cyclothymic Disorder

- Delusional Disorder**
- 16- 297.1● Delusional Disorder
- 297.3 Shared Psychotic Disorder

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

Psychotic Disorder Nec

- 295.40 Schizophreniform Disorder, Unspecified
- 295.41 Schizophreniform Disorder, Subchronic
- 295.42 Schizophreniform Disorder, Chronic
- 295.43 Schizophreniform Disorder, Subchronic, W/Acute Exacerbation
- 295.44 Schizophreniform Disorder, Chronic, With Acute Exacerbation
- 295.45 Schizophreniform Disorder, In Remission
- 295.70 Schizoaffective Disorder, Unspecified
- 295.71 Schizoaffective Disorder, Subchronic
- 295.72 Schizoaffective Disorder, Chronic
- 295.73 Schizoaffective Disorder, Subchronic, W/Acute Exacerbation
- 295.74 Schizoaffective Disorder, Chronic, With Acute Exacerbation
- 295.75 Schizoaffective Disorder, In Remission
- 298.8 Brief Psychotic Disorder
- 17- 298.9● Psychotic Disorder NOS

Neurotic, Personality and Other Nonpsychotic Disorders

Anxiety Disorder

- 18- 300.00●Anxiety Disorder NOS
- 300.01 Panic Disorder, Without Agoraphobia
- 300.02 Generalized Anxiety Disorder
- 300.11 Conversion Disorder
- 300.12 Dissociative Amnesia
- 300.13 Dissociative Fugue
- 300.14 Dissociative Identity Disorder
- 300.15 Dissociative Disorder NOS
- 300.21 Panic Disorder, With Agoraphobia
- 300.22 Agoraphobia Without history of Panic Disorder
- 300.23 Social Phobia
- 300.29 Specific Phobia
- 300.3 Obsessive-Compulsive Disorder
- 300.6 Depersonalization Disorder
- 300.7 Hypochondriasis; Body Dysmorphic Disorder
- 300.82 Undifferentiated Somatoform Disorder; Somatization Disorder NOS
- 300.9 Unspecified Mental Disorder (Nonpsychotic)
- 308.3 Acute Stress Reaction
- 309.81 Post-Traumatic Stress Disorder

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

Personality Disorder

- 301.0 Paranoid Personality Disorder
- 301.20 Schizoid Personality Disorder
- 301.22 Schizotypal Personality Disorder
- 301.4 Obsessive-Compulsive Personality Disorder
- 301.50 Histrionic Personality Disorder
- 301.6 Dependent Personality Disorder
- 301.7 Antisocial Personality Disorder
- 301.81 Narcissistic Personality Disorder
- 301.82 Avoidant Personality Disorder
- 301.83 Borderline Personality Disorder

- 19- 301.9● Personality Disorder NOS
- 310.1 Personality Change Due to...(Indicate Med.Condition)

Psychosexual Disorder

- 302.2 Pedophilia
- 302.3 Transvestic Fetishism
- 302.4 Exhibitionism
- 302.6 Gender Identity Disorder in Children
- 302.6 Gender Identity Disorder NOS
- 302.70 Sexual Dysfunction NOS
- 302.71 Hypoactive Sexual Desire Disorder
- 302.72 Female Sexual Arousal Disorder
- 302.72 Male Erectile Disorder
- 302.73 Female Orgasmic Disorder
- 302.74 Male Orgasmic Disorder
- 302.75 Premature Ejaculation
- 302.76 Dyspareunia (Not Due to a General Medical Condition)
- 302.79 Sexual Aversion Disorder
- 302.81 Fetishism
- 302.82 Voyeurism
- 302.83 Sexual Masochism
- 302.84 Sexual Sadism
- 302.85 Gender Identity Disorder in Adolescents or Adults
- 302.89 Frotteurism
- 302.9 Paraphilia NOS

- 20- 302.9● Sexual Disorder NOS
- 306.51 Vaginismus (Not Due to a General Medical Condition)

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

Special Symptom Nce

- 307.0 Stuttering
- 307.1 Anorexia Nervosa
- 307.20 Tic Disorder NOS
- 307.21 Transient Tic Disorder
- 307.22 Chronic Motor or Vocal Tic Disorder
- 307.23 Tourette's Disorder
- 307.3 Stereotypic Movement Disorder
- 21- 307.9● Communication Disorder NOS

Medication Induced Disorder

- 332.1 Neuroleptic-Induced Parkinsonism
- 333.1 Medication-Induced Postural Tremor
- 333.7 Neuroleptic-Induced Acute Dystonia
- 333.82 Neuroleptic-Induced Tardive Dyskinesia
- 333.90 Medication-Induced Movement Disorder NOS
- 333.92 Neuroleptic Malignant Syndrome
- 333.99 Neuroleptic-Induced Acute Akathisia
- 21.1 995.2● Adverse Effects of Medication, NOS

Sleep Disorder

- 307.42 Primary Insomnia; Insomnia Related to...(Indicate Axis I or Axis II)
- 307.44 Hypersomnia Related to...(Indicate Axis I or Axis II)
- 307.44 Primary Hypersomnia
- 307.45 Circadian Rhythm Sleep Disorder
- 307.46 Sleep Terror Disorder; Sleepwalking Disorder
- 22- 307.47●Dyssomnia NOS; Parasomnia NOS; Nightmare Disorder
- 347 Narcolepsy

Eating Disorder

- 23- 307.50●Eating Disorder NOS
- 307.51 Bulimia Nervosa
- 307.52 Pica
- 307.53 Rumination Disorder
- 307.59 Feeding Disorder of Infancy or Early Childhood

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

Adjustment Disorder

- 309.0 Adjustment Disorder With Depressed Mood
- 309.21 Separation Anxiety Disorder
- 309.24 Adjustment Disorder With Anxiety
- 309.28 Adjustment Disorder With Mixed Anxiety and Depressed Mood
- 309.3 Adjustment Disorder With Disturbance of Conduct
- 309.4 Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
- 24- 309.9● Adjustment Disorder, Unspecified

Disruptive Behavior Disorder

- 312.81 Conduct Disorder, Childhood Onset Type
- 312.82 Conduct Disorder, Adolescent Onset Type
- 312.89 Conduct Disorder, Unspecified Type
- 25- 312.9● Disruptive Behavior Disorder NOS

Impulse Control Disorder

- 26- 312.30● Impulse Control Disorder NOS
- 312.31 Pathological Gambling
- 312.32 Kleptomania
- 312.33 Pyromania
- 312.34 Intermittent Explosive Disorder
- 312.39 Trichotillomania

Alcohol and Drug Abuse

Alcohol Dependence

- 27- 303.90● Alcohol Dependence, Unspecified
- 303.91 Alcohol Dependence, Continuous
- 303.92 Alcohol Dependence, Episodic
- 303.93 Alcohol Dependence, In Remission

Drug Dependence

- 304.00 Opioid Dependence, Unspecified
- 304.01 Opioid Dependence, Continuous
- 304.02 Opioid Dependence, Episodic
- 304.03 Opioid Dependence, In Remission
- 304.10 Sedative, Hypnotic, or Anxiolytic Dependence, Unspecified
- 304.11 Sedative, Hypnotic, or Anxiolytic Dependence, Continuous
- 304.12 Sedative, Hypnotic, or Anxiolytic Dependence, Episodic

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- 304.13 Sedative, Hypnotic, or Anxiolytic Dependence, In Remission
- 304.14 304.20 Cocaine Dependence, Unspecified
- 304.21 Cocaine Dependence, Continuous
- 304.22 Cocaine Dependence, Episodic
- 304.23 Cocaine Dependence, In Remission
- 304.30 Cannabis Dependence, Unspecified
- 304.31 Cannabis Dependence, Continuous
- 304.32 Cannabis Dependence, Episodic
- 304.33 Cannabis Dependence, In Remission
- 304.40 Amphetamine Dependence, Unspecified
- 304.41 Amphetamine Dependence, Continuous
- 304.42 Amphetamine Dependence, Episodic
- 304.43 Amphetamine Dependence, In Remission
- 304.50 Hallucinogen Dependence, Unspecified
- 304.51 Hallucinogen Dependence, Continuous
- 304.52 Hallucinogen Dependence, Episodic
- 304.53 Hallucinogen Dependence, In Remission
- 304.60 Inhalant Dependence, Unspecified
- 304.61 Inhalant Dependence, Continuous
- 304.62 Inhalant Dependence, Episodic
- 304.63 Inhalant Dependence, In Remission
- 304.80 Polysubstance Dependence, Unspecified
- 304.81 Polysubstance Dependence, Continuous
- 304.82 Polysubstance Dependence, Episodic
- 304.83 Polysubstance Dependence, In Remission

- 28-
- 304.90●Other (or Unknown) Substance, or Phencyclidine Dependence, Unspecified
 - 304.91 Other (or Unknown) Substance, or Phencyclidine Dependence, Continuous
 - 304.92 Other (or Unknown) Substance, or Phencyclidine Dependence, Episodic
 - 304.93 Other (or Unknown) Substance, or Phencyclidine Dependence, In Remission
 - 304.94 In Remission
 - 305.10 Nicotine Dependence

Alcohol Abuse

- 303.00 Alcohol Intoxication, Unspecified
- 303.01 Alcohol Intoxication, Continuous
- 303.02 Alcohol Intoxication, Episodic
- 303.03 Alcohol Intoxication, In Remission

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- 29-** 305.00●Alcohol Abuse, Unspecified
305.01 Alcohol Abuse, Continuous
305.02 Alcohol Abuse, Episodic,
305.03 Alcohol Abuse, In Remission

Drug Abuse

- 305.20 Cannabis Abuse, Unspecified
305.21 Cannabis Abuse, Continuous
305.22 Cannabis Abuse, Episodic
305.23 Cannabis Abuse, In Remission
305.30 Hallucinogen Abuse, Unspecified
305.31 Hallucinogen Abuse, Continuous
305.32 Hallucinogen Abuse, Episodic
305.33 Hallucinogen Abuse, In Remission
305.40 Sedative, Hypnotic, or Anxiolytic Abuse, Unspecified
305.41 Sedative, Hypnotic, or Anxiolytic Abuse, Continuous
305.42 Sedative, Hypnotic, or Anxiolytic Abuse, Episodic
305.43 Sedative, Hypnotic, or Anxiolytic Abuse, In Remission
305.50 Opioid Abuse, Unspecified
305.51 Opioid Abuse, Continuous
305.52 Opioid Abuse, Episodic
305.53 Opioid Abuse, In Remission
305.60 Cocaine Abuse, Unspecified
305.61 Cocaine Abuse, Continuous
305.62 Cocaine Abuse, Episodic
305.63 Cocaine Abuse, In Remission
305.70 Amphetamine Abuse, Unspecified
305.71 Amphetamine Abuse, Continuous
305.72 Amphetamine Abuse, Episodic
305.73 Amphetamine Abuse, In Remission
- 30-** 305.90●Other, Mixed Abuse, Unspecified
Caffeine, Other (or Unknown) Substance Intoxication,
Inhalant, Phencyclidine Abuse, Unspecified
- 305.91 Other, Mixed Abuse, Continuous
Caffeine, Other (or Unknown) Substance Intoxication,
Inhalant, Phencyclidine Abuse, Continuous

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

305.92 Other, Mixed Abuse, Episodic
Caffeine, Other (or Unknown) Substance Intoxication,
Inhalant, Phencyclidine Abuse, Episodic

305.93 Other, Mixed Abuse, In Remission
Caffeine, Other (or Unknown) Substance Intoxication,
Inhalant, Phencyclidine Abuse, In Remission

Disorders First Evident in Infancy, Childhood, or Adolescence

Disorder of Infancy, Childhood and Adolescence

- 313.23 Selective Mutism
- 313.81 Oppositional Defiant Disorder
- 313.82 Identity Problem
- 313.89 Reactive Attachment Disorder of Infancy or Early Childhood
- 31- 313.9● Disorders of Infancy, Childhood, or Adolescence NOS
- 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
- 314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type
or Predominantly Hyperactive-Impulsive Type
- 314.9 Attention-Deficit/Hyperactivity Disorder NOS

Pervasive Developmental Disorder

- 299.00 Autistic Disorder, Active
- 299.01 Autistic Disorder, Residual
- 299.10 Childhood Disintegrative Disorder, Active
- 299.11 Childhood Disintegrative Disorder, Residual
- 299.80 Pervasive Developmental Disorder NOS, Active
Asperger's, Rett's Disorder, Active
- 32- 299.81●Pervasive Developmental Disorder NOS, Residual
Asperger's, Rett's Disorder, Residual
- 307.6 Enuresis (Not Due to a General Medical Condition)
- 307.7 Encopresis, Without Constipation and Overflow Incontinence
- 315.00 Reading Disorder
- 315.1 Mathematics Disorder
- 315.2 Disorders of Written Expression
- 315.32 Expressive Language Disorder; Mixed Receptive-Expressive Language
Disorder
- 315.39 Phonological Disorder
- 315.4 Developmental Coordination Disorder
- 315.9 Learning Disorder NOS

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

Mild Mental Retardation

33- 317●Mild Mental Retardation

Moderate to Profound Mental Retardation

34- 318.0● Moderate Mental Retardation
318.1 Severe Mental Retardation
318.2 Profound Mental Retardation

Unspecified Mental Retardation

35- 319● Mental Retardation, Severity Unspecified

Other

Psychic Factors Associated with Disease

307.80 Pain Disorder Associated With Psychological Features
307.89 Pain Disorder Associated With Both Psych. and Med. Condition
36- 316● (Specified Psych. Factor) Affecting...(Indicate Med.Cond.)

Factitious Disorder

300.16 Factitious Disorder W/ Psychological Signs and Symptoms
37- 300.19●Other and Unspecified Factitious Illness

Other Suspected Mental Condition

780.9 Age Related Cognitive Decline
38- V71.09 Other Suspected Mental Condition

Diagnosis Deferred

38.1-799.9 Diagnosis Deferred on Axis I or Axis II

Suicide

39- Suicide (Ideation) - Thinking about, including talking about,
taking one's life. (ICD-9-CM-300.9)

40- Suicide (Attempt/Gesture) - Any effort directed at harming
one's self. The distinction between an attempt and a gesture is
a judgment call and should be documented in the "Comment"
section of the entry. (ICD-9-CM-300.9)

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR
DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the
narrative.

- 41-** Suicide (Completed) - Intentional self inflicted death requires followup to complete suicide registry information. (ICD-9-CM-798.1)

Abuse Category

Child Abuse (Victim)

- 995.50 Child Abuse (Suspected), Unspecified - Willful abuse of children requiring protective actions, unspecified type of abuse. (995.50)
- 42-** Child Abuse (Suspected), Unspecified - Willful abuse of children requiring protective actions, unspecified type of abuse. (995.50)
- 995.54 Physical Abuse of Child (Victim) - Willful abuse of children requiring protective actions, physical abuse primary concern. (995.54)
- 42.1-** Child Abuse (Suspected), Physical - Willful abuse of children requiring protective actions, physical abuse primary concern. (V15.49)*
- 42.2-** Child Abuse (Suspected), Emotional - Willful abuse of children requiring protective actions, emotional abuse primary concern. (V15.49)*
- 995.53 Sexual Abuse of Child (Victim) - Willful abuse of children requiring protective actions, sexual abuse primary concern. (995.53)
- 42.3-** Child Abuse (Suspected), Sexual - Willful abuse of children requiring protective actions, sexual abuse primary concern. (V15.49)*
- Partner Abuse (Victim)**
- 43-** Partner Abuse (Suspected), Unspecified - Willful abuse of partner, unspecified type. (995.80)
- 43.1-** Partner Abuse (Suspected), Physical - Willful abuse of partner, physical abuse primary concern. (V15.49)*
- 43.2-** Partner Abuse (Suspected), Emotional - Willful abuse of partner, emotional abuse primary concern. (V15.49)*

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

43.3-	Partner Abuse (Suspected), Sexual - Willful abuse of partner, sexual abuse primary concern.	(V15.49)*
	Adult Abuse (Victim)	
995.80	Adult Abuse, (Suspected), Unspecified - Willful abuse of adult requiring protective actions. Unspecified type.	(995.80)
44-	Adult Abuse, (Suspected) - Willful abuse of adult requiring protective actions. Unspecified type	(995.80)
44.1-	Adult Abuse, (Suspected), Physical - Willful abuse of adult requiring protective actions. Physical abuse of primary concern.	(V15.49)*
44.2-	Adult Abuse, (Suspected), Emotional - Willful abuse of adult requiring protective actions. Emotional abuse of primary concern.	(V15.49)*
44.3-	Adult Abuse, (Suspected), Sexual - Willful abuse of adult requiring protective actions. Sexual abuse of primary concern.	(V15.49) *
	Child/Partner/Adult Abuse (Perpetrator)	
45-	Abusive Behavior (Alleged), Unspecified - Client is alleged to have abused other individual. Unspecified type.	(V15.49)*
45.1-	Abusive Behavior (Alleged), Physical - Client is alleged to have abused other individual. Physical abuse of primary concern.	(V15.49)*
45.2-	Abusive Behavior (Alleged), Emotional - Client is alleged to have abused other individual. Emotional abuse of primary concern.	(V15.49)*
45.3-	Abusive Behavior (Alleged), Sexual (Exc. Rape) - Client is alleged to have abused other individual. Sexual abuse of primary concern.	(V15.49)*
	Rape	
46-	Rape (Alleged/Suspected) - Any act of sexual assault that is forced upon an unwilling individual.	(V71.5)

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- 46.1-** Rape (Alleged/Perpetrator) - Any act of sexual assault that is forced upon an unwilling individual. Alleged Perpetrator focus. (V71.5)
- 46.2-** Incest Survivor - Current or historical information which is relevant to present situation/problem/issue. (V15.49)

Neglect Category

- 995.52- Neglect of Child (Victim) - Children suffering from nutritional neglect.\ (995.52)
- 47-** Child Neglect (Suspected) - Children suffering from emotional, social, economic, medical or educational deprivation because parents or guardians are unable, or unwilling, to meet their needs.(V61.29)
- 48-** Adult Neglect (Suspected) - Adults suffering from emotional, social, economic, medical or educational deprivation because family or guardians are unable, or unwilling, to meet their needs. (995.80)
- 49-** Partner Neglect (Suspected) - Adult partner suffering from emotional, social, economic, medical or educational deprivation because partner is unable, or unwilling, to meet their needs. (995.80)

Family Like Problems Category

- 51-ARBD** Alcohol Related Birth Defect (V13.7)*
- 51.1-FAS** Fetal Alcohol Syndrome (760.71)
- 52-** Child or Adolescent Antisocial Behavior - Dyssocial behavior or gang activity in child or adolescent without manifest psychiatric disorder (V71.02)
- 53-** Adult/Child Relationship - Problems associated with dysfunctional relationships between parent/guardian and child/parent. (V61.20)
- 54-** Uncomplicated Grief Reaction - Excludes bereavement as a brief depressive reaction. (V62.82)

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

- ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

54.1-	Death- Issues associated with or precipitated by a death, including notifications, arrangements, transportation, documentation, etc. (excludes grief reaction)	(V68.89)
54.2-	Dying - Issues associated with dying. Includes advance directives, wills and other arrangements.	(V62.89)
55-	Illness in Family - Social dysfunction and adjustment of family members or significant others to physical or mental illness of a family member.	(V61.49)
56-	Marital Problem - Conflict related to marital problems on a continuum from premarital counseling to coping with the marriage relationship. (NOTE: Use problem code 58 for broken family/separation/divorce.)	(V61.10)
57-	Sibling Conflict - Problems related to children growing up together whether related or not, a family circumstance, not a marital problem or an adult-child relationship.	(V61.8)
58-	Separation/Divorce - Adjustment and/or dysfunction related to coping with separation or divorce.	(V61.0)
59-	Family Conflict- Conflict with family members.	(V61.8)
60-	Interpersonal Relationships - Interpersonal problems not specified elsewhere.	(V62.81)
61-	Adult Antisocial Behavior - Dyssocial behavior or gang activity in adult without manifest psychiatric disorder.	(V71.01)
62-	Other Family Life Problems	(V62.89)

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

Pregnancy/Childbirth Problems Category

- 63-** Pregnancy Conflict - Problems associated with the pregnancy, including counseling about options, feelings about options, referrals for financial assistance, etc. (V61.8)*
- 64-** Adoption - Includes all problems regarding permanent placement of a child with other than natural parents, e.g., resources, planning and followup. (V68.89)*
- 65-** Family Planning - Emotional and technical problems of contraceptive use or nonuse, family size/spacing of offspring, sterility. (V26.4)
- 66-** Pregnancy Concerns - Problems relating to pregnancy and childbearing. (V61.8)*
- 67-** Teenage Pregnancy - Problems related to childbearing in the group 19 years of age and under. (V61.8)*
- 68-** High Risk Pregnancy - Mother is in a specified high risk group. (V23.9)
- 69-** Other Childbearing Problems. (V61.8)*

Socioeconomic Problems Category

- 78-** Alternate Health Resources - Enrollment for and utilization of Medicare/Medicaid, Children's Medical Services, or any other alternate or third party payment for medical care. (V68.89)
- 79-** Financial Needs/Assistance - Problems related to lack of fiscal resources, payments from public assistance programs or economic resources. (V60.2)
- 79.1-** Inadequate Personal Resources - Problems complicated by the lack personal resources and/or a social support system. (V61.9)

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- | | | |
|--------------|---|---------|
| 79.2- | Inadequate Access to Resources - Problems complicated by the lack of accessible resources to deal with the patient's problem. | (V63.0) |
| 80- | Housing - Problems related to lack of adequate housing or associated with the improvement of current living quarters. | (V60.1) |
| 81- | Nutrition - Problems associated with adequate nourishment, food resources, eligibility and access to food programs. | (V65.3) |
| 82- | Employment - Problems related to lack of a job, underemployment, employment assistance and on the job problems | (V62.0) |
| 83- | Transportation - Problems related to inadequate or unavailable transportation. | (V60.8) |
| 84- | Co-Worker Difficulties - Problems resulting from work. | (V62.2) |
| 85- | Other Socioeconomic Problems not included here. | (V60.8) |

Sociolegal Problems Category

- | | | |
|------------|---|---------|
| 86- | Forensic: Criminal - Problems related to issues involving criminal law. | (V62.5) |
| 87- | Forensic: Civil - Problems related to issues involving civil law. | (V62.5) |
| 88- | Other Sociolegal Problems | (V62.5) |

Educational/Life Problems Category

- | | | |
|------------|---|---------|
| 89- | Academic Problem - Difficulty with academic performance. | (V62.3) |
| 90- | School Behavior Problem - Failure to conform to school rules and regulations. | (V40.3) |

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

- 91- School Dropout - Failure to attend school or complete education before legal school attendance age or academic level is reached; problems due to unexcused absences from school. (V62.3)
- 92- Vocational Rehabilitation - Problems associated with evaluation and planning for training or readjustment in employment. (V57.2)
- 93- Peer Conflict - Problems of socialization with contemporaries. (V62.81)
- 94- Phase of Life Problems - Problems associated with life circumstances or phase of life. (V62.89)

Administrative Problems Category

- 95- Continuing Education - Issues concerned with meeting continuing education requirements for certification or licensure. (V65.40)
- 96- Training Needs - Ongoing assessment/evaluation of educational needs of staff and planning toward meeting those needs. (V65.49)
- 97- Administration - Problems, issues and concerns in program management. (V68.9)
- 98- Employee Assistance Program (V65.49)
- 99- Other Administrative Problems - If the problem cannot properly be coded from the list above. (V68.9)

* V-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

● ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative.

MH/SS to PCC Link

Background

Use the MH/SS system to record a broad range of problems and issues in a wide variety of circumstances. Passing this information to the PCC was complicated by several issues. One of the most pressing concerns was how to characterize the purpose of the visit.

PCC coding is organized around the ICD-9-CM diagnostic codes. The MH/SS problem list covers a broad range of descriptive behavioral data and includes the full range of DSM-IV diagnostic codes as a specific subset within that range.

If the POV was characterized using a DSM diagnostic code, the issue of what was passed to the PCC was clear. The American Psychiatric Association, in conjunction with the Health Care Finance Administration, published a standardized crosswalk from the DSM-III-R diagnostic system to the ICD-9-CM diagnostic system. This crosswalk was developed primarily to address third-party billing issues and the early test versions of this module used the crosswalk. The DSM IV diagnostic codes are even more coordinated with the updated ICD-9-CM and they are used in this version of the software.

However, a significant number of the issues of concern to MH/SS programs related to the recording of data that was not adequately addressed by either of DSM or ICD. Suicides, domestic violence, child abuse and neglect, adult abuse and neglect, a wide range of family life problems, and the socioeconomic issues that aggravate these issues cannot adequately be identified using the DSM or ICD codes, even when used with the supplemental V-codes and Axis IV Problem Categories. Over several years, groups of professionals from the Mental Health and Social Service programs have developed a fairly comprehensive set of problem codes that more adequately address these information concerns. However, the expansion of the coding only deals with one part of the recording issue. If useful data is going to be passed routinely to the PCC, the issues of which data would be passed and how it would be passed continued to be of considerable concern.

Each patient-related contact is added to that patient's visit file in the MH/SS system as the data is entered. If that visit meets the reporting criteria for a PCC visit, a record can be automatically added to the PCC visit file for that patient at the same time. Each addition consists of two parts of information: the coded purpose of visit (POV) and the narrative that accompanies that code. Both pieces of information are required data in the MH/SS reporting system and are captured in separate fields on the contact form.

Coding the POV

In the initial instructions for coding the purpose of visit, only DSM codes were allowed for defining psychosocial problems. Program directors soon pointed out that while not all users of the system were trained to use the DSM diagnostic system, most were quite capable of characterizing the problem in general diagnostic terms. To preclude this option by requiring a DSM diagnostic categorization could lead to underreporting of specific issues as well as improperly reported diagnoses. Moreover, these issues could be further aggravated by the process of passing data to the PCC and their subsequent use in the billing module that uses PCC data. Problem codes defining psychosocial problems could only be passed using more general V-codes and this stricture was an additional concern.

To address these concerns, the problem codes were restructured within the psychosocial problem category and mapped to the most general DSM diagnostic code within these subcategories. A qualifying note was then added to the information as it was crosswalked to the PCC. This note distinguished levels of certainty by adding the phrase “Diagnostic Impression” to the ICD-9-CM codes passed to PCC as a result of conversions of MH/SS problem codes in the psychosocial problems category. DSM diagnoses were passed as ICD-9-CM diagnoses and problem codes were passed as the most general ICD-9-CM diagnosis along with the qualifying note.

Selected sets of problem codes, mainly those dealing with abuse and neglect issues, were expanded to allow providers options to identify specific types of abuse and to choose the information shared with the PCC in the narrative. With several of these options, the choice of code governs the data shared with the PCC. Options range from all to very little information. In a few other cases where the nature of the problem might disclose more information than the patient or the provider felt appropriate, very general ICD V-codes were used to identify the POV in the PCC. In all of these instances where the problem was “shrouded” using a very general V-code, a phrase identifying the provider who reported this contact, as a source for further information, was added to the narrative as the data was passed to the PCC.

The remainder of the MH/SS problem codes were matched with the most appropriate ICD-9-CM V-code. Since the MH/SS range of problem codes is more extensive than the list of V-codes, very distinct MH/SS problem codes may pass the same V-code. As with the psychosocial problem codes, greater detail is retained in the MH/SS file whereas more general information is passed to the PCC.

With the exception of the five problem/POV codes associated with administrative problems, all the codes can be used to report effort in the MH/SS data file. MH/SS Problem codes and DSM Codes can be passed to the PCC when appropriate.

POV Narrative

In addition to the issue of which coding to use, field programs expressed a range of opinions about what narrative information should be automatically passed to the PCC. Opinions varied from wanting the detailed provider narrative (to ensure that other clinicians were totally aware of the specifics of the MH/SS contact) to reservations about passing any information at all.

The diagnosis and the narrative passed with that diagnosis were issues of concern. Even though the POV, as an ICD code, is passed in each instance, it usually does not show up on the health summary. The POV is available in the PCC database as a data item that can be used in searches or as a key for report writing. It is used in the billing module, also. The narrative information is generally passed as written by the provider and shows as the POV on the health summaries. For these reasons, the wording associated with certain diagnoses was of particular concern. The terms themselves could arouse anxiety about confidentiality when the information was widely shared.

To address these concerns, five options governing which data is passed to the PCC have been developed. These are described in detail here. In general, the table in Appendix XX shows the crosswalk from MH/SS problem codes to ICD-9-CM codes and the narrative description associated with each of these ICD codes that is passed as the provider narrative (see option 3). The crosswalk is the same with Option 4 and 5, but the narrative that passes is different. The provider's exact narrative passes with option 4 and the canned narrative defined by the program passes with Option 5. Option 2 passes only a standard POV and narrative defined by the program. Option 1 passes nothing.

1. No Link Active

The data link between the two components is not turned on. No data is passed to the PCC visit file from the MH/SS system.

2. Pass Standard Code and Narrative

The data link is enabled. Patient contacts recorded in the MH/SS visit file are passed to the PCC visit file. The specific ICD-9-CM code and canned narrative defined by the program is used in all cases; for example, V69.5 - Family Resource Program.

3. MH/SS Developed Crosswalk

The data link is on. Patient contacts recorded in the MH/SS file are passed to the PCC visit file according to the manner in which the POV is coded.

- If the POV is identified using a DSM-IV diagnostic code, the equivalent ICD-9-CM diagnostic code and the narrative as recorded by the provider is added to the PCC visit file.
- If a psychosocial problem is characterized using a MH/SS problem code as a POV, the ICD-9-CM code along with the canned narrative as shown, prefaced with the phrase "Diagnostic Impression" is passed to the PCC. All of these instances are marked with a bullet in the table in Appendix XX.

- If the POV is characterized using an MH/SS problem code other than a psychosocial problem, the ICD-9-CM code and the canned narrative, as shown in the table in Appendix XX, are passed to the PCC Visit file. Note the following:
 - Where a potentially sensitive issue is identified using an MH/SS problem code, a more benign ICD-9-CM code (usually a relatively general V-Code), along with the standardized narrative as shown, appended with the phrase “See (provider's name) for details of this contact” is passed to the PCC. All of these instances are marked with an asterisk in the table in Appendix XX.
 - Two sets of exceptions, encompassing four problems, apply to these procedures.
 - For MH/SS problem codes 39 (Suicide Ideation) and 40 (Suicide Attempt/Gesture), the ICD-9-CM code and canned descriptive narrative is accompanied by the provider's narrative as written.
 - For MH/SS problem codes 42 (Child Abuse) and 44 (Adult Abuse), the ICD-9-CM codes for those issues (995.5 and 995.81, respectively) have been added as acceptable DSM codes to allow an additional option for what gets passed to the PCC. When these codes are used to characterize the POV, each gets passed “as is” (recall these are ICD codes), along with the provider's narrative as written.

4. Pass All Data as Entered

All DSM and problem codes are passed as ICD-9-CM codes, as shown in the crosswalk in Appendix XX, along with the narrative as written by the provider.

5. Pass Codes and Canned Narrative

This option is a variation of Option 2. Both DSM and PC codes are converted to ICD-9-CM codes, as shown in the crosswalk in Appendix, and passed with a single canned narrative defined by the program for all contacts.

MH/SS PROBLEM CODE TO ICD9 CROSSWALK (Medical/Social Problems Category)

This Crosswalk shows how POVs characterized with a Problem Code are passed to the PCC as an equivalent ICD-9-CM Diagnosis or V-Code along with the identified narrative modifiers, where appropriate, using the MH/SS Developed Crosswalk (OPTION3) of the MH/SS to PCC linkage options.

Read from left to right, e.g., if the provider uses Problem Code 10, "Alcohol Psychoses" will be the label that is stored in the MH/SS File. The ICD-9-CM diagnostic code 291.0 with the phrase "Diagnostic Impression" will be passed to the PCC. The ICD-9-CM label for that diagnostic code is "Delirium Tremens." So the POV will be stored in MH/SS as PC 10, "Alcoholic Psychoses" and passed to PCC as "Diagnostic Impression: Delirium Tremens" 291.0.

This listing only shows how the Problem Codes will pass data to the PCC. All the DSM-IV diagnosis will pass the same numeric equivalent ICD-9-CM diagnostic information to the PCC. Be aware that while the codes are numerical equivalents the label nomenclature may vary slightly from one system to the other. Examples of this are reflected in the table below.

1	Health/Homemaker Needs	V60.4	No Family Able to Care
2	Cross Cultural Issue	V62.9*	Psychosocial Circumstances Nos 3
3	Unspecified Mental Problem	V40.9*	Mental/Behavior Prob Nos
4	Physical Disabil/Rehab	V57.9	Rehabilitation Proc Nos
5	Physical Illness, Acute	V15.89	Hx Health Hazards Nec
6	Physical Illness, Chron/Term	V15.89	Hx Health Hazards Nec
7	Non-Compliance w/Treatment	V15.81	Hx Past Non-Compliance
8	Failed Appointment, No Show	V15.81	Hx of Past Non-Compliance

(Organic Mental Disorders)

9	Senile and Pre-Senile Cond.	290.0	Senile Dementia, Uncomplicated
10	Alcohol Psychoses	291.0	Delirium Tremens
11	Drug Withdrawals Syndrome	292.0	Drug Withdrawal Syndrome
12	Organic Mental Disorder	294.9	Organic Brain Syndrome Nos

(Other Psychoses)

13	Schizophrenic Disorder	295.90	Schizophrenia Nos-Unspec
14	Major Depressive Disorder	311.	Depressive Disorder Nec
15	Bipolar Disorder	296.7	Bipolar Affective Nos
16	Delusional Disorder	297.9	Paranoid State Nos
17	Psychotic Disorders Nce	298.9	Psychosis Nos

(Neurotic and Other Nonpsychotic)

18	Anxiety Disorder	300.00	Anxiety State Nos
19	Personality Disorder	301.9	Personality Disorder Nos
20	Sexual Disorder	302.9	Psychosexual Dis Nos
21	Special Symptoms Nce	307.9	Special Symptoms Nec/Nos
21.1	Medication Induced Disorder	995.2	Adverse Effect of Drugs, Unspec.
22	Sleep Disorder	307.47	Nonorganic Sleep Dis Nos
23	Eating Disorder	307.50	Eating Disorder Nos
24	Adjustment Disorder	309.9	Adjustment Reaction Nos
25	Disruptive Behavior Disorder	312.9	Conduct Disturbance Nos
26	Impulse Control Disorder	312.30	Impulse Control Dis Nos

(Alcohol and Drug Abuse)

27	Alcohol Dependence	303.90	Alcoh Dep Nec/Nos-Unspec
28	Drug Dependence	304.90	Drug Dependence Nos-Unspec
29	Alcohol Abuse	305.00	Alcohol Abuse-Unspec
30	Drug Abuse	305.90	Drug Abuse Nec/Mixed/Nos-Unspe

(Infant, Childhood or Adolescent)

31	Infant, Child or Adol Disorder	313.9	Emotional Dis Child Nos
32	Development Disorders	299.81	Pervasive Developmental Disorder
33	Mild Mental Retardation	317.0	Mild Mental Retardation
34	Moderate to Profound	318.0	Mod Mental Retardation
35	Unspec. Mental Retardation	319.	Mental Retardation Nos

(Other)

36	Psychic-Factors Associate	316.	Psychic Factors & Other Dis
38.1	Diagnosis Deferred	799.90	Diagnosis Deferred
37	Factitious Disorder	300.19	Factitious Ill Nec/Nos
38	Other Suspected Mental Cond..	V71.09	Observ Mental Cond Nec

(Suicide)

39	Suicide Ideation	300.9	Suicide Ideation
40	Suicide Attempt/Gesture	300.9	Suicide Attempt/Gesture
41	Suicide Completed	798.1*	Death

(Abuse)

995.50	Child Abuse (Suspected), Unspe.	995.50	"...Provider Narrative.."
42	Child Abuse (Suspected), Unspe.	995.50	Child Abuse, Unspecified
995.54	Physical Abuse of Child (Victim)	995.54	Child Physical Abuse
42.1	Child Abuse (Suspected), Phys.	V15.49*	Psychological Trauma, Nec
42.2	Child Abuse (Suspected), Emot.	V15.49*	Psychological Trauma, Nec
995.53	Sexual Abuse of Child (Victim)	995.53	Child Sexual Abuse
42.3	Child Abuse (Suspected), Sexual	V15.49*	Psychological Trauma, Nec
43	Partner Abuse (Suspected), Unspe.	995.80	Adult Maltreatment, Unspec.
43.1	Partner Abuse (Suspected), Phys.	V15.49*	Psychological Trauma, Nec
43.2	Partner Abuse (Suspected), Emot.	V15.49*	Psychological Trauma, Nec
43.3	Partner Abuse (Suspected), Sex.	V15.49*	Psychological Trauma, Nec
995.80	Adult Maltreat. (Suspected), Unspe.	995.80	"...Provider Narrative..."
44	Adult Abuse (Suspected), Unsp.	995.80	Adult Maltreatment, Unspec.
44.1	Adult Abuse (Suspected), Phys.	V15.49*	Psychological Trauma, Nec.
44.2	Adult Abuse (Suspected), Emot.	V15.49*	Psychological Trauma, Nec.
44.3	Adult Abuse (Suspected), Sex.	V15.49*	Psychological, Trauma, Nec.
45	Abuse Beh (Alleged), Unspec.	V15.49*	Psychological Trauma, Nec.
45.1	Abuse Beh (Alleged), Physical	V15.49*	Psychological Trauma, Nec.
45.2	Abuse Beh (Alleged), Emotion.	V15.49*	Psychological Trauma, Nec.
45.3	Abuse Beh (Alleged), Sexual	V15.49*	Psychological Trauma, Nec.
46	Rape (Alleged/Victim)	V71.5	Observ Following Rape
46.1	Rape (Alleged/Perpetrator)	V71.5	Observ Following Rape
46.2	Incest Survivor	V15.49	Psychological Trauma, Nec.

(Neglect)

995.52	Neglect of Child (Victim)	995.52	Child Neglect (Nutritional)
47	Child Neglect (Suspected)	V61.29	Parent-Child Problems, Other
48	Adult Neglect (Suspected)	995.80	Adult Maltreatment, Unspec.
49	Partner Neglect (Suspected)	995.80	Adult Maltreatment, Unspec.

(Family Life Problems)

51	Alcohol Related Birth Defect	V13.7*	Hx Perinatal Problems
51.1	Fetal Alcohol Syndrome	760.71	Material Alcohol Aff.
52	Child/Adolescent Antisocial	V71.02	Obsv-Adolesc Antisoc Beh
53	Adult/Child Relationship	V61.20	Parent/Child Prob. Nos.
54	Uncomplicated Grief Reaction	V62.82	Bereavement, Uncomplicated
54.1	Death, Issues Concerned With	V68.89	Other Specified Admin. Purp.
54.2	Dying, Issues Concerned With	V62.89	Other Life Circumstances
55	Illness in Family	V61.49	Family Health Problem Nec.
56	Marital Problem	V61.10	Marital Problems
57	Sibling Conflict	V61.8	Family Circumstances Nec.
58	Separation/Divorce	V61.0	Family Disruption
59	Family Conflict	V61.8	Family Circumstances Nec.
60	Interpersonal Relationships	V62.81	Interpersonal Problem Nec.
61	Adult Antisocial Behavior	V71.01	Obsv-Adult Anti-Soc Beh
62	Other Family Life Problem	V62.89	Psychological Stress Nec.

(Pregnancy/Childbirth Problems)

63	Pregnancy Conflict	V61.8*	Family Circumstances Nec.
64	Adoption	V68.89*	Administrative Effort Nec.
65	Family Planning	V26.4	Procreative Mgmt-Counseling
66	Pregnancy Concerns	V61.8*	Family Circumstances Nec.
67	Teenage Pregnancy	V61.8*	Family Circumstances Nec.
68	High Risk Pregnancy	V23.9	Suprv High Risk Preg Nos
69	Other Childbearing Problems	V61.8*	Family Circumstances Nec.

(Socioeconomic Problems)

78	Alternate Health Resources	V68.89	Administrative Effort Nec.
79	Financial Needs	V60.2	Economic Problem
79.1	Inadequate Personal Resources	V61.9	Unspecified Family Circum.
79.2	Inadequate Access to Resources	V63.0	Remote From Hosp. Other Fac.
80	Housing	V60.1	Inadequate Housing
81	Nutritional	V65.3	Dietary Surveil/Counsel
82	Employment	V62.0	Unemployment
83	Transportation	V60.8	Housing/Econom Circum Nec.
84	Co-Worker Difficulties	V62.2	Occup Circumstances Nec.
85	Other Socioeconomic Probs	V60.8	Housing/Econom Circum Nec.

(Sociolegal Problems)

86	Forensic	V62.5	Legal Circumstances
87	Civil	V62.5	Legal Circumstances
88	Other Sociolegal	V62.5	Legal Circumstances

(Educational/Life Problems)

89	Academic Problem	V62.3	Educational Circumstances
90	School Behavior Problem	V40.3	Behavioral Problems Nec.
91	School Dropout	V62.3	Educational Circumstances
92	Vocational Rehabilitation	V57.2	Occupat/Vocation Therapy
93	Peer Conflict	V62.81	Interpersonal Probl Nec.
94	Phase of Life Problem	V62.89	Psychological Stress Nec.

(Administrative)

95	Continuing Education	V65.40	Other Counseling, Nec.
96	Training Needs	V65.49	Other Specified Counseling
97	Administration	V68.9	Unspecified Administrative Purpose
98	Employee Assistance Program	V65.49	Other Specified Counseling
99	Other Administrative	V68.9	Unspecified Administrative Purpose